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MEDICARE PROSPECTIVE PAYMENT SYSTEM: ITS IMPLICATIONS FOR IOWA AND THE OLDER AMERICANS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

EXAMINING THE MEDICARE PROSPECTIVE PAYMENT SYSTEM AND ITS IMPLICATIONS FOR IOWA AND THE OLDER AMERICANS ACT

AUGUST 5, 1985

DES MOINES, IA

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MEDICARE PROSPECTIVE PAYMENT SYSTEM: ITS IMPLICATIONS FOR IOWA AND THE OLDER AMERICANS ACT

MONDAY, AUGUST 5, 1985

U.S. Senate,
Subcommittee on Aging,
Committee on Labor and Human Resources,
Des Moines, IA.

The subcommittee met at 1 p.m. in the Wallace Building auditorium, Des Moines, IA, Senator Charles E. Grassley (chairman of the subcommittee) presiding.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator Grassley. The hearing will come to order.

I want to say thanks to all of you who are here, and hopefully there will be people in and out all afternoon, and particularly those of you who we invited to testify, both from Government as well as from the private sector, thank you very much.

I'd like to welcome you to this hearing on the Medicare prospective payment system and its implications for Iowa and the Older Americans network. I want to thank you all for attending.

I would like to have you allow me a few administrative preliminaries, to get them out of the way. We've asked witnesses to limit their oral presentation to approximately 7 minutes to leave plenty of time for questions. For those with prepared statements, I would like to have a copy which, under normal procedure, as well as the procedures of this field hearing, will be entered into the record in full. So your summary of 7 minutes still does not deprive anybody of having their full statement printed in the record, which record is actually printed and can be disseminated, and we will try to disseminate it. But just in case you wonder about that, if you think you've been left out or something, don't be afraid, in 1 month or so, to ask us where it is.

The purpose of this hearing is to examine the Medicare prospective payment system at its 2-year mark. Now, I don't know whether you realize it, but we are 2 years down the road, and we assured ourselves, as well as people affected by it, that there would be a 3-year review on a very comprehensive basis. I want to look at it now because it seems to me to impact upon rural areas somewhat differently than was anticipated, and we want to look at it at a 2-year period of time. In those 2 years, the prospective payment system has had a tremendous impact on incentives to provide efficient and cost-effective health care under the Medicare Program.

When the Congress passed the prospective payment system in Public Law 98-121, it recognized that a basic reason for rapid cost increases was the way we paid hospitals. The traditional retrospective cost-based method of hospital reimbursement provided no incentives—or at least everybody ought to agree not enough incentives—for hospitals to be cost conscious. In the past, Medicare rewarded increased expenditures—not necessarily prudent management.

Now, under the prospective payment system, Medicare payments are made at predetermined, fixed rates representing the average cost of treating a patient according to the primary diagnosis. During the 3-year transition period, a declining portion of the prospective payment system payment is based on a hospital's historic costs, and an increasing portion is based on a combination of regional and national diagnostic-related group rates. In fiscal year 1987 and thereafter, Medicare payments will be determined totally under a national DRG methodology.

Changing the cost-based hospital reimbursement system has promoted greater efficiency and slowed the inflationary spiral of hospital expenditures. The rise in Medicare part A has dropped to a projected 12.5 percent this year from a high of 22 percent growth in 1981. The hospital insurance trust fund, which was projected to be depleted in the early 1990's, is now expected to be solvent through the next decade.

However, as we examine this program we need to look not only at its effect on costs, but also its effect on quality of care to beneficiaries. That's the whole purpose of any of the Medicare and Medicaid Programs. Recognizing that the prospective payment system has built-in incentives for hospitals to both admit patients and to discharge them earlier, Congress created peer review organizations to provide utilization and quality-of-care review. They are the so-called watchdogs of the Medicare system, charged with the important role of monitoring the validity of diagnostic information, readmission rates, appropriateness of services, and other measures of quality of care.

All of our witnesses this afternoon are concerned about the maintenance of quality of care. Previous congressional testimony has suggested that patients are being discharged from our hospitals, to coin an overly used phrase, "sicker and quicker." Continual monitoring is needed to ensure that patients are not placed at increased risk.

An important cost containment aspect of the prospective payment system is that it gives hospitals incentives to keep patients in an acute care setting only as long as it is medically necessary. If hospitals are discharging more patients who need post-acute care, we must try to meet the increased demand for skilled nursing facilities, rehabilitation hospitals and swing beds. The swing bed program has enabled us to increase the availability of skilled-level beds as well as to find use for underutilized hospital capacity. Perhaps modifications are necessary in the swing bed program, skilled nursing facility reimbursement or other post-acute care services to promote access to the most appropriate level of care for Medicare patients.

As we discuss the impact of prospective reimbursement on beneficiaries, I also hope to touch on its impact on the Nation's Older Americans Act network. As the author of the Senate bill which reauthorized the Older Americans Act last year for a period of 3 years, I am interested in whether resources are being shifted to provide more community-based health care services.

There is little doubt that our health care providers have been the most dramatically affected by the implementation of the prospective payment system. As our Iowa PRO has emphasized, it is an inescapable fact that physicians now have to be more aware of the financial impact of their practice decisions. Hospitals, as well, have strong incentives to provide the most cost-efficient care possible. Some efficient hospitals have done well under prospective reimbursement, yet there are inequities in the system in need of redress.

Many of our Iowa hospitals have suffered from a rural/urban DRG rate differential which simply does not reflect actual historical costs. Standardized nonlabor reimbursement under the prospective payment system varies up to 54 percent higher for urban than for rural hospitals in our region. HCFA and the Congress have been well aware that flawed Bureau of Labor Statistics wage data has substantially penalized small and rural hospitals in calculating the labor cost component. Congress directed HCFA, in the Deficit Reduction Act of 1984, to develop an improved wage index that would compensate rural hospitals fairly. After much delay, HCFA has finally responded with a more accurate area wage index based on an actual hospital survey.

I have introduced legislation, which is S. 1376, to implement the new gross wage index and waive the retroactive application mandated under current law. Although this new index would partially mitigate the disparity between rural and urban DRG rates, this is just one of the steps that Congress must take to refine the prospective payment system to provide equity among all hospitals.

I want to look forward to the evaluation by our witnesses of the prospective payment system in the delivery of health care in Iowa. The comments we hear today will contribute to the accumulating record on what changes are needed to ensure quality and to provide fairness to all health care users.

We have on our first panel—I want to welcome you here—three individuals who represent health agencies key to the evaluation of the Medicare prospective payment system. Our first witness today is Mr. Bartlett Fleming. Mr. Fleming is the Associate Administrator for Management and Support Systems of the Health Care Financing Administration. The Health Care Financing Administration is a Federal agency which administers the Medicare Program and is charged with the formidable task of implementing a new prospective method of reimbursement, reimbursing hospitals. In my work on the Senate Finance Committee, we have many occasions to request comments from your agency, Mr. Fleming, and I have appreciated the cooperation of your Administrator, Dr. Davis, and her interests in refining and improving the delivery of health care under the Medicare Program.

We also have Dr. Robert Mandsager from Marshalltown. He is president of the Iowa Foundation for Medical Care, which is Iowa's peer review organization. His organization is the physician-based group that performs medical care review under contract with HCFA. Our Iowa peer review organization is unique, in that it has in its membership two-thirds of all Iowa physicians. We're happy to have you here, Doctor, and to recognize the important role your organization is playing in monitoring utilization and quality of care.

Our third witness is Mr. Paul Pietzsch of Des Moines. Mr. Pietzsch is president of the Health Policy Corp. of Iowa. This corporation is a designated health system agency that has been very instrumental in developing health care cost containment strategies for our State.

So I thank each of you for being here, and I'd ask you to give your statements within the time limits I suggested in the order I introduced you, and then at the tail end I'll have questions of each of you.

So would you proceed, Dr. Fleming.

STATEMENT OF BARTLETT S. FLEMING, ASSOCIATE ADMINISTRATOR FOR MANAGEMENT AND SUPPORT SERVICES, HEALTH CARE FINANCING ADMINISTRATION; ROBERT MANDSAGER, M.D., PRESIDENT, IOWA FOUNDATION FOR MEDICAL CARE; AND PAUL M. PIETZSCH, PRESIDENT, HEALTH POLICY CORPORATION OF IOWA

Mr. FLEMING. It's my pleasure to be here, sir. Thank you very much for the invitation and the opportunity to visit Iowa. It's my first visit, but I'm a midwesterner by origin, so I feel at home.

Medicare's prospective payment system is probably the single most important improvement in the Medicare Program since it began in 1966. Over the long run it should prove to be a very valuable weapon in our battle to control the rise of health care costs, while assuring adequate access and quality care for our program beneficiaries.

As you know, hospitals began phasing into the system during the fiscal year beginning October 1983, at the start of their respective cost-accounting periods. A total of 5,405, about 81 percent of all Medicare certified hospitals, are now on the system and about 83 percent of all payments for inpatient hospital services in fiscal year 1985 have been under the prospective payment system. This success is a real tribute to the cooperation of hospitals, fiscal intermediaries and other organizations who have worked so closely with us in this effort.

The Congress provided a 3-year transition period in order to allow high-cost hospitals time to change their behavior—to respond to the incentive, if you will—to live within the national rates.

During fiscal year 1985, the payment is 50 percent hospital specific and 50 percent a Federal rate, of which 75 percent is a regional average and 25 percent a national average.

In the coming fiscal year, 1986, the scheduled third year of the phase-in, the rate will be 25 percent hospital specific and the remaining 75 percent will be based half on a regional rate and half on the national rate.

In fiscal year 1987, a fully national rate would be based solely on the national urban and rural averages.

Let me turn for just a minute to some of the concerns about the rural provisions of the prospective payment system. Medicare prospective payment recognizes and responds to the somewhat unique patterns of providing hospital care in rural areas.

For sole community hospitals, those hospitals in rural areas which, by reason of factors such as isolated location, weather conditions, travel conditions, et cetera, payments are the sole source of inpatient hospital services reasonably available in the geographic area to Medicare beneficiaries, payments are being made predominantly on the basis of the individual hospital's historic costs, rather than moving toward a fully national Federal rate. The Congress directed the Secretary to review the urban/rural payment differential to determine if this is the most appropriate reimbursement formula to meet the special needs of sole community hospitals. We expect to submit our report to Congress in December of this year.

Special provision is made for certain rural hospitals, known as referral centers, which have characteristics of urban hospitals. These hospitals will receive the urban rather than the rural payment rate. Among the criteria for identifying such hospitals are numbers of discharges and case-mix measures. Approximately 90 hospitals have been designated as rural referral centers—I believe there's 5 in Iowa.

As I mentioned earlier, the Federal portion of the prospective payment rate is modified by an area wage index, reflecting the actual wage levels of the urban or rural area in which the hospital is located. For the first 2 years of prospective payment, the wage index had been based on data supplied by the Bureau of Labor Statistics, as you mentioned in your opening remarks. Because that BLS data failed to distinguish between full- and part-time workers, Congress directed that the Department seek an alternative data source. That was quite a monumental undertaking.

We conducted a direct survey of all participating hospitals and constructed two alternative indexes—a gross index based on average hourly wages of all hospital workers and an adjusted index which excluded hospital-based physicians, interns and residents, contract labor and employees not involved in providing hospital services. Since the wage index measures wages in one area in relation to other areas, whenever one area increases, another one must decrease. Because the law requires that any revised index be applied for hospital cost reporting periods beginning on or after October 1, 1983, we must consider not only the future impact of a revised index, but also the retroactive impact and its effect particularly on those areas where overpayments must be recovered. We are seeking input from Congress and other interested groups regarding whether either of the new indexes should be selected to replace the current index.

You mentioned quality of care and access to care in your opening remarks. Let me turn to that for just a moment.

One of our primary goals is to maintain quality of care under prospective payment. High-quality hospital care has a long-standing tradition in this Nation, and our prospective payment system was developed with that commitment in mind. We have reason to believe that the prospective payment system may actually enhance the quality of care provided to Medicare beneficiaries.

I might just say parenthetically that I don't think there's any issue that we spend more time on generically in HCFA and in the Department than quality of care. In fact, last year our senior staff was at a retreat; it was just a day and a half. And fully the first half of that retreat was devoted specifically to concern for quality of care, is quality of care being addressed?

The prospective payment system has the advantage of encouraging hospitals to specialize in those types of cases which they can treat efficiently and effectively. Most studies have shown that as hospitals specialize in providing services, the quality of care improves. This is because the performance of some procedures are enhanced by a high volume of cases which helps to maintain proficiency in treatment. These studies indicate that when certain services are provided in hospitals with low volume, quality of care tends to suffer.

When the prospective payment system legislation was being debated by the Congress many believed that inherent to PPS is an incentive to admit patients to the hospital. Rather than being concerned about access to hospital services, opponents and proponents of PPS have worried that admissions would be excessive, thereby exposing Medicare beneficiaries to unwarranted risks and needless suffering. Medicare admissions under PPS have followed a downward trend in admissions for the non-Medicare population seen nationally over the last several years.

Working in partnership with the prospective payment system is the Peer Review Organization, which you also referred to in your opening remarks. In changing the incentives under which hospitals provide services, both Congress and the administration were aware that medical review had to change from its historical form under the Professional Standards Review Organization Program. The PRO amendments in the Tax Equity and Fiscal Responsibility Act of 1982 set a firm foundation for this redirection. We believe the PRO Program will enhance peer review under Medicare by directing review activities specifically toward those quality, cost and utilization areas most likely to be affected by the new prospective payment system.

A major provision of the new PRO Program is the use of measurable performance objectives. Through the use of these objectives in our contracts, PRO's are required to accomplish goals they themselves set. This new approach is a vast improvement over what prevailed before, and ensures that PRO's will monitor actively the quality of care in their State. In the scope of work for the PRO contracts are generic areas relating to the review of admissions, utilization and quality of care. In this way we set the foundation for performance-based contracts, but left to the PRO bidders the responsibility to specify what particular utilization and quality issues would be addressed locally.

Mr. Chairman, a number of critics have suggested that under PPS hospitals may be prematurely discharging Medicare patients. Let me emphasize that we believe that one premature discharge is too many, and we have no evidence that there is a significant problem with premature discharges under PPS.

The level of readmissions has not changed since the pre-PPS period. As a safeguard against such practices we require PRO's to report all cases of hospital readmissions that occur within 7 days of a hospital discharge. Where the PRO finds that the readmission resulted because of a premature discharge, they are now required to deny payment for the readmission. In these instances, the hospital may not, in turn, charge the beneficiary for the readmission.

Our concern for access and quality extends beyond the PRO hospital review. For example, a measure designed to assure access to needed care is the swing-bed program. This program enables small rural hospitals to provide skilled nursing facility-level care to Medicare beneficiaries who no longer need the intensity of hospital care, but do have access to an SNF bed. Over 300 hospitals are currently participating in this program, of which about 92 are in the Iowa area—or in the State of Iowa.

In another area, the survey and certification program protects the health and safety of beneficiaries in Medicare facilities, such as hospitals and skilled nursing facilities. Through cooperative efforts with the Joint Commission on the Accreditation of Hospitals and the State survey and certification agencies, this program works to uphold the standards and conditions for participating in the Medicare Program. We have recently modified this program and are now phasing in an increased focus on patient outcomes.

Mr. Chairman, in creating the prospective payment system, Congress and the administration made a long-term commitment to changing incentives in the health care sector to reward efficiency and cost containment. At the same time, the Congress put a strong mechanism in place to assure that quality is maintained. We believe that the vast majority of physicians and hospitals will continue to provide high quality and appropriate care. However, it is our responsibility to assure that this is the case and we have made this a high priority.

[The prepared statement of Mr. Fleming follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF
BARTLETT S. FLEMING
ASSOCIATE ADMINISTRATOR
FOR
MANAGEMENT AND SUPPORT SERVICES
HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
DES MOINES, IOWA

AUGUST 5, 1985

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM PLEASED TO BE HERE TO DISCUSS THE MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS), PARTICULARLY AS IT AFFECTS RURAL HEALTH CARE AREAS. WE SHARE YOUR INTEREST IN ASSURING THAT HIGH QUALITY MEDICAL CARE CONTINUES TO BE PROVIDED UNDER THE NEW PAYMENT SYSTEM AND WANT TO DESCRIBE OUR ACTIVITIES TO ACCOMPLISH THIS AIM.

BACKGROUND

MEDICARE'S PPS IS PROBABLY THE SINGLE MOST IMPORTANT IMPROVEMENT IN THE MEDICARE PROGRAM SINCE IT BEGAN IN 1966. FOR OVER 17 YEARS, HOSPITALS WERE REIMBURSED ON A REASONABLE COST BASIS WHICH FAILED TO ENCOURAGE EFFICIENCY SINCE WE REIMBURSED BASICALLY WHATEVER COSTS WERE INCURRED. UNDER PPS, WITH THE AMOUNT OF PAYMENT SET IN ADVANCE AND BASED PRIMARILY ON THE PATIENT'S DIAGNOSIS, HOSPITALS WHICH ORGANIZE AND PROVIDE SERVICES IN AN EFFICIENT AND COST-EFFECTIVE MANNER ARE REWARDED. OVER THE LONG RUN, PPS SHOULD PROVE TO BE A VALUABLE TOOL IN OUR BATTLE TO CONTROL THE RISE OF HEALTH CARE COSTS WHILE ASSURING ADEQUATE ACCESS AND QUALITY CARE FOR OUR PROGRAM BENEFICIARIES.

HOSPITALS BEGAN PHASING INTO PPS DURING THE FISCAL YEAR BEGINNING OCTOBER 1, 1983, AT THE START OF THEIR RESPECTIVE COST-ACCOUNTING PERIODS. ALL HOSPITALS, EXCEPT THOSE EXEMPT FROM THE SYSTEM, WERE ON PPS BY SEPTEMBER 30, 1984. AS WE

PREPARE TO MOVE INTO THE FINAL YEAR OF TRANSITION TO A NATIONAL RATE WE CAN TAKE PRIDE IN THE SMOOTHNESS IN WHICH IT WAS ACCOMPLISHED. A TOTAL OF 5,405 OR 81 PERCENT OF ALL MEDICARE CERTIFIED HOSPITALS ARE NOW ON PPS AND ABOUT 83 PERCENT OF ALL PAYMENTS FOR INPATIENT HOSPITAL SERVICES IN FISCAL YEAR 1985 HAVE BEEN UNDER PPS. THIS SUCCESS IS A REAL TRIBUTE TO THE COOPERATION OF HOSPITALS, FISCAL INTERMEDIARIES AND OTHER ORGANIZATIONS WHO HAVE WORKED SO CLOSELY WITH US IN THIS EFFORT.

THE NEW PAYMENT SYSTEM IS NOW IN THE SECOND YEAR OF A THREE-YEAR PHASE-IN FROM A COMBINATION OF HOSPITAL-SPECIFIC AND REGIONAL RATES TO A FULLY NATIONAL PROSPECTIVE RATE. CONGRESS PROVIDED THE THREE YEAR TRANSITION PERIOD IN ORDER TO ALLOW HIGH COST HOSPITALS TIME TO CHANGE THEIR BEHAVIOR TO LIVE WITHIN THE NATIONAL RATES. IN FISCAL YEAR 1984, THE FIRST YEAR OF PPS PHASE-IN, HOSPITALS WERE PAID A RATE OF WHICH 75 PERCENT WAS BASED ON A HOSPITAL'S HISTORICAL COSTS (THE HOSPITAL-SPECIFIC RATE) AND 25 PERCENT WAS A FEDERAL RATE WHICH WAS BASED ON REGIONAL COSTS. DURING FISCAL YEAR 1985, THE PAYMENT IS 50 PERCENT HOSPITAL-SPECIFIC AND 50 PERCENT A FEDERAL RATE OF WHICH 75 PERCENT IS A REGIONAL AVERAGE AND 25 PERCENT A NATIONAL AVERAGE. IN FISCAL YEAR 1986, THE SCHEDULED THIRD YEAR OF THE PHASE-IN, THE RATE WILL BE 25

PERCENT HOSPITAL-SPECIFIC AND THE REMAINING 75 PERCENT WILL BE BASED HALF ON A REGIONAL RATE AND HALF ON THE NATIONAL RATE. IN FISCAL YEAR 1987, A FULLY NATIONAL RATE WOULD BE BASED SOLELY ON THE NATIONAL URBAN AND RURAL AVERAGES. ALL URBAN AND RURAL FEDERAL RATES ARE, OF COURSE, ADJUSTED FOR DIFFERENCES IN AREA WAGE LEVELS.

SPECIAL RURAL PROVISIONS

THE MEDICARE PPS RECOGNIZES AND RESPONDS TO THE SOMEWHAT UNIQUE PATTERNS OF PROVIDING HOSPITAL CARE IN RURAL AREAS.

-- FOR SOLE COMMUNITY HOSPITALS--THOSE HOSPITALS IN RURAL AREAS WHICH, BY REASON OF FACTORS SUCH AS ISOLATED LOCATION, WEATHER CONDITIONS, TRAVEL CONDITIONS OR ABSENCE OF OTHER HOSPITALS, ARE THE SOLE SOURCES OF INPATIENT HOSPITAL SERVICES REASONABLY AVAILABLE IN A GEOGRAPHIC AREA TO MEDICARE BENEFICIARIES--PAYMENTS ARE BEING MADE PREDOMINATELY ON THE BASIS OF THE INDIVIDUAL HOSPITAL'S HISTORIC COSTS, RATHER THAN MOVING TOWARD A FULLY NATIONAL FEDERAL RATE. THE CONGRESS DIRECTED THE SECRETARY TO REVIEW THE URBAN/RURAL PAYMENT DIFFERENTIAL TO DETERMINE IF THIS IS THE MOST APPROPRIATE

REIMBURSEMENT FORMULA TO MEET THE SPECIAL NEEDS OF SOLE COMMUNITY HOSPITALS. WE EXPECT TO SUBMIT OUR REPORT ON THIS ISSUE BY DECEMBER OF THIS YEAR, THE DATE SPECIFIED BY THE CONGRESS. IN ADDITION, A SOLE COMMUNITY HOSPITAL MAY QUALIFY FOR SPECIAL ASSISTANCE IF A SHARP DECLINE IN ADMISSIONS FOR REASONS OVER WHICH THE HOSPITAL HAS NO CONTROL CREATES FINANCIAL HARDSHIP. OVER 365 HOSPITALS QUALIFY AS SOLE COMMUNITY HOSPITALS.

-- SPECIAL PROVISION IS MADE FOR CERTAIN RURAL HOSPITALS, KNOWN AS REFERRAL CENTERS, WHICH HAVE CHARACTERISTICS OF URBAN HOSPITALS. THESE HOSPITALS WILL RECEIVE THE URBAN RATHER THAN THE RURAL PAYMENT RATE. AMONG THE CRITERIA FOR IDENTIFYING SUCH HOSPITALS ARE NUMBERS OF DISCHARGES AND CASE-MIX MEASURES. APPROXIMATELY 150 HOSPITALS HAVE BEEN DESIGNATED AS RURAL REFERRAL CENTERS.

-- AS I MENTIONED EARLIER, THE FEDERAL PORTION OF THE PROSPECTIVE PAYMENT RATE IS MODIFIED BY AN AREA WAGE INDEX, REFLECTING THE ACTUAL WAGE LEVELS OF THE URBAN OR RURAL AREA IN WHICH THE HOSPITAL IS LOCATED. FOR

THE FIRST TWO YEARS OF THE PPS, THE WAGE INDEX HAD BEEN BASED ON DATA SUPPLIED BY THE BUREAU OF LABOR STATISTICS (BLS). BECAUSE THE BLS DATA FAILED TO DISTINGUISH BETWEEN FULL AND PART TIME WORKERS, CONGRESS DIRECTED THAT THE DEPARTMENT SEEK AN ALTERNATIVE DATA SOURCE. WE CONDUCTED A DIRECT SURVEY OF ALL PARTICIPATING HOSPITALS AND CONSTRUCTED TWO ALTERNATIVE INDEXES--A GROSS INDEX BASED ON AVERAGE HOURLY WAGES OF ALL HOSPITAL WORKERS AND AN ADJUSTED INDEX WHICH EXCLUDED HOSPITAL-BASED PHYSICIANS, INTERNS AND RESIDENTS, CONTRACT LABOR AND EMPLOYEES NOT INVOLVED IN PROVIDING HOSPITAL SERVICES. SINCE THE WAGE INDEX MEASURES WAGES IN ONE AREA IN RELATION TO OTHER AREAS, WHENEVER ONE AREA INCREASES ANOTHER MUST DECREASE. BECAUSE THE LAW REQUIRES THAT ANY REVISED INDEX BE APPLIED FOR HOSPITAL COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1983, WE MUST CONSIDER NOT ONLY THE FUTURE IMPACT OF A REVISED INDEX BUT ALSO THE RETROACTIVE IMPACT AND ITS EFFECT PARTICULARLY ON THOSE AREAS WHERE OVERPAYMENTS MUST BE RECOVERED. WE ARE SEEKING INPUT FROM CONGRESS AND OTHER INTERESTED GROUPS REGARDING WHETHER EITHER OF THE NEW INDEXES SHOULD BE SELECTED TO REPLACE THE CURRENT INDEX.

QUALITY AND ACCESS

ONE OF OUR PRIMARY GOALS IS TO MAINTAIN QUALITY OF CARE UNDER PPS. HIGH QUALITY HOSPITAL CARE HAS A LONG-STANDING TRADITION IN THIS NATION AND OUR PROSPECTIVE PAYMENT SYSTEM WAS DEVELOPED WITH THAT COMMITMENT IN MIND. WE HAVE REASON TO BELIEVE THAT THE PROSPECTIVE PAYMENT SYSTEM MAY ACTUALLY ENHANCE THE QUALITY OF CARE PROVIDED TO MEDICARE BENEFICIARIES. THIS SYSTEM HAS THE ADVANTAGE OF ENCOURAGING HOSPITALS TO SPECIALIZE IN THOSE TYPES OF CASES WHICH THEY CAN TREAT EFFICIENTLY AND EFFECTIVELY. MOST STUDIES HAVE SHOWN THAT AS HOSPITALS SPECIALIZE IN PROVIDING SERVICES, THE QUALITY OF CARE IMPROVES. THIS IS BECAUSE THE PERFORMANCE OF SOME PROCEDURES ARE ENHANCED BY A HIGH VOLUME OF CASES WHICH HELPS TO MAINTAIN PROFICIENCY IN TREATMENT. THESE STUDIES INDICATE THAT WHEN CERTAIN SERVICES ARE PROVIDED IN HOSPITALS WITH LOW VOLUME, QUALITY OF CARE TENDS TO SUFFER.

WHEN THE PPS LEGISLATION WAS BEING DEBATED BY THE CONGRESS MANY BELIEVED THAT INHERENT TO PPS IS AN INCENTIVE TO ADMIT PATIENTS TO THE HOSPITAL. RATHER THAN BEING CONCERNED ABOUT ACCESS TO HOSPITAL SERVICES, OPPONENTS AND PROPONENTS OF PPS HAVE WORRIED THAT ADMISSIONS WOULD BE EXCESSIVE, THEREBY EXPOSING MEDICARE BENEFICIARIES TO UNWARRANTED RISKS AND needless suffering. Fortunately, these concerns have not been justified. Medicare admissions under PPS have followed the downward trend in admissions for the non-Medicare population seen nationally over the last several years.

Working in partnership with PPS is the Peer Review Organization (PRO) program. In changing the incentives under which hospitals provide services, both Congress and the Administration were aware that medical review had to change from its historical form under the Professional Standards Review Organization program. The PRO amendments in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) set a firm foundation for this redirection. We believe the PRO program will enhance peer review under Medicare by directing review activities specifically toward those quality, cost, and utilization areas most likely to be affected by the new PPS.

A major provision of the new PRO program is the use of measurable performance objectives. Through the use of these objectives in our contracts, PROs are required to accomplish goals they themselves set. This new approach is a vast improvement over what prevailed before and ensures that PROs will monitor actively the quality of care in their State.

In the scope of work for the PRO contracts are generic areas relating to the review of admissions, utilization and quality of care. In this way, we set the foundation for performance-based contracts, but left to the PRO bidders the responsibility to specify what particular utilization and quality issues would be addressed locally. It was also the PRO's responsibility to propose quantifiable performance objectives for addressing these issues. For example, one of the utilization objectives of the Iowa PRO is to reduce hospital admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory surgical setting or an outpatient basis. The Iowa PRO also is working toward reducing by 5 percent the risk of mortality associated with selected procedures and/or conditions requiring hospitalization to fulfill a quality objective.

Mr. Chairman, a number of critics have suggested that under PPS hospitals may be prematurely discharging Medicare patients. Let me emphasize that we believe that one case of premature discharge is too many and we have no evidence that there is a significant problem with premature discharges under PPS. As a safeguard against such practices we require PROs to report all cases of hospital readmissions that occur within

SEVEN DAYS OF A HOSPITAL DISCHARGE. WHERE THE PRO FINDS THAT THE READMISSION RESULTED BECAUSE OF A PREMATURE DISCHARGE, THEY ARE NOW REQUIRED TO DENY PAYMENT FOR THE READMISSION. IN THESE INSTANCES, THE HOSPITAL MAY NOT, IN TURN, CHARGE THE BENEFICIARY FOR THE READMISSION. WHERE THE PRO IDENTIFIES OTHER INSTANCES OF POOR QUALITY IT CAN TAKE OTHER CORRECTIVE ACTIONS, INCLUDING PROGRAM SANCTIONS.

OUR CONCERN FOR ACCESS AND QUALITY EXTENDS BEYOND PRO HOSPITAL REVIEW. FOR EXMAPLE, A MEASURE DESIGNED TO ASSURE ACCESS TO NEEDED CARE IS THE SWING-BED PROGRAM. THIS PROGRAM ENABLES SMALL RURAL HOSPITALS TO PROVIDE SNF-LEVEL CARE TO MEDICARE BENEFICIARIES WHO NO LONGER NEED THE INTENSITY OF HOSPITAL CARE, BUT DO NOT HAVE ACCESS TO A SNF BED. OVER 300 HOSPITALS ARE CURRENTLY PARTICIPATING IN THIS PROGRAM.

IN ANOTHER AREA, THE SURVEY AND CERTIFICATION PROGRAM PROTECTS THE HEALTH AND SAFETY OF BENEFICIARIES IN MEDICARE FACILITIES, SUCH AS HOSPITALS AND SKILLED NURSING FACILITIES (SNFS). THROUGH COOPERATIVE EFFORTS WITH THE JOINT COMMISSION ON THE ACCREDIATION OF HOSPITALS AND THE STATE SURVEY AND CERTIFICATION AGENCIES, THIS PROGRAM WORKS TO UPHOLD THE STANDARDS AND CONDITIONS FOR PARTICIPATING IN THE MEDICARE PROGRAM. WE HAVE RECENTLY MODIFIED THIS PROGRAM AND ARE NOW PHASING IN AN INCREASED FOCUS ON PATIENT OUTCOMES.

CONCLUSION

MR. CHAIRMAN, IN CREATING THE PROSPECTIVE PAYMENT SYSTEM, CONGRESS AND THE ADMINISTRATION MADE A LONG-TERM COMMITMENT TO CHANGING INCENTIVES IN THE HEALTH CARE SECTOR TO REWARD EFFICIENCY AND COST CONTAINMENT. AT THE SAME TIME, THE CONGRESS PUT A STRONG MECHANISM IN PLACE TO ASSURE THAT QUALITY IS MAINTAINED. WE BELIEVE THAT THE VAST MAJORITY OF PHYSICIANS AND HOSPITALS WILL CONTINUE TO PROVIDE HIGH QUALITY AND APPROPRIATE CARE. HOWEVER, IT IS OUR RESPONSIBILITY TO ASSURE THAT THIS IS THE CASE AND WE HAVE MADE THIS A HIGH PRIORITY.

THANK YOU FOR THE OPPORTUNITY TO APPEAR HERE TODAY AND I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator **Grassley**. Thank you, Dr. Fleming.

Dr. **Mandsager**. Senator Grassley, I am Dr. Mandsager, a surgeon from Marshalltown. I am the president of the Iowa Foundation for Medical Care and am representing the foundation at today's hearing. The foundation is Iowa's Peer Review Organization and contracts with the Health Care Financing Administration to conduct a review for the Medicare Program.

We appreciate this opportunity to offer testimony on the prospective payment system. It has done as much to change the practice of medicine and the health care system as did the Medicare Program itself when it was instituted 20 years ago last month.

Medicare, coupled with the Hill-Burton Act, which made available Federal funds to promote hospital construction, held out the promise that health care for the elderly would be greatly enhanced in quality and accessibility. That promise has been largely realized because of these programs and the tremendous increase in medical technology and improvements in the practice of medicine.

The Federal Government, however, now aware of the rapidly increasing cost of these support programs, is seeking ways to control costs and simultaneously assure the same level of quality and accessibility.

There are two questions before us: Can it be done; and if so, who shall do it?

We at the foundation believe it can be done and that physicians are the best qualified group to balance cost concerns against quality concerns. We willingly accept the confidence placed in us to do so.

There has been no question that the use of hospital services by Medicare beneficiaries has been reduced in Iowa since the prospective payment system began. In calendar year 1984, the number of discharges per 1,000 Medicare beneficiaries declined by 15 percent. The number of days of care per 1,000 Medicare beneficiaries declined by 25 percent.

The question of quality of care, however, is a nagging one. Our responsibility to monitor quality of care is limited to specific areas. Our primary responsibility is to ensure that hospital admissions are appropriate. We have done this by establishing a set of criteria, approved by Iowa physicians of all specialties, and used daily as a screening tool by our nurse coordinators throughout the State. If a given case does not fit the criteria or there are other questions about it, the case is referred to a foundation physician for a decision. Only physicians are allowed to make recommendations for a denial of reimbursement. Approximately 80 percent of all admissions are approved by using a nurse criteria and 20 percent are referred for physician review. In Iowa at present, 1 percent of Medicare admissions result in a recommendation for denial of reimbursement. In 110 of the 129 Iowa communities where there are hospitals, physicians from the local communities conduct all admission review activities.

If the attending physician, patient, or hospital is dissatisfied with the decision, a reconsideration process is available.

There are other aspects of the quality question that are beyond the IFMC's purview. We have no authority to conduct so-called continued-stay reviews, in which patients are evaluated for the continued need of acute care services on a periodic basis while they are in the hospital.

As you know, PPS carries strong financial incentives to discharge patients as soon as possible.

Under PRO regulations, the IFMC is required to keep track of all hospital readmissions that occur within 7 days of discharge and to evaluate whether the second admission was the result of an earlier premature discharge. This mechanism provides one indicator of quality of care. Since PPS became fully operational in July 1984, 413 cases, or 9.5 percent, of the 4,339 readmissions within 7 days of discharge were found to be the result of what were felt to be premature discharges.

When it comes to quality concerns, our emphasis is first on educating physicians about the prospective payment system and their responsibilities. In instances where we identify substandard quality of care, we bring it to the attention of the physician. I can report that we have detected no gross or flagrant instances of poor quality of care that are serious enough to require us to recommend that a physician or provider be prohibited from participation in the Medicare Program. We are monitoring the situation closely, however.

Where minor quality problems are identified or where physicians admit patients inappropriately, we have an intensified monitoring process. Presently, 137 of the State's 3,500 physicians, or 4 percent, are subject to this "focused" review program.

The IFMC does not dispute other congressional testimony and study results that conclude that patients are leaving the hospital sooner than before PPS went into effect. In Iowa, the length of a hospital stay has been decreased by a full day since PPS began. In only a very small number of cases have the patients been discharged to a level of care that placed them at increased risk. The fact is, that prior to PPS, many patients were kept at the acute care level longer than was medically necessary. The IFMC position is that medically, the situation is now more nearly correct under the PPS.

Because of the manner in which PRO regulations have been established, review organizations have no authority to review followup, out-of-hospital care patients might need to complete their recovery. We can only draw conclusions about quality of care when patients reenter the acute care system, but no authority exists to permit monitoring of whether needed followup care was provided between hospitalizations.

One of the effects of our review to encourage the most appropriate care settings has been the growth of outpatient services. And although the use of outpatient services is growing rapidly, we have no authority to review these services.

The IFMC believes that PRO's should be used as intended—that is to review health care provided to Medicare patients. As acute care is decreasing, alternate forms of care are increasing—physician office care, outpatient care, home health care, outpatient procedures, care provided by health maintenance organizations, and care in nursing homes. These are all areas in which the authority of a PRO to conduct review is weak, being challenged or nonexistent. To be truly a guardian of quality of care and to assure the appropriateness of care, PRO's should be allowed to respond to these changes in the health care system.

You have asked our position on waiver of liability. Waiver of liability provides financial protection that is necessary for hospitals because of the inherent uncertainty in medicine and the honest disagreement that sometimes exists. Medicine is not so exact a science that complete agreement can be attained.

Regarding our position on Senate bill 1376, we defer to other witnesses today. They are more qualified to address this issue. Our general position is that the Medicare reimbursement structure for hospitals should be fair.

I have expanded on my remarks and provided further information on other issues in a written statement.

Thank you.

[Additional remarks of Dr. Mandsager follow:]

Expanded Remarks for the Record

Robert Mandsager, M.D.
President, Iowa Foundation for Medical Care
Before the Senate Subcommittee on Aging

Des Moines, Iowa

August 5, 1985

Note: The following are responses to questions contained in "Memorandum to Witnesses" of July 23, 1985.

Does health service price data need to be made available to the public, and can it be made available in a meaningful and responsible manner?

The connection between price and level of service is a tenuous one. Price data are meaningless unless they are tied to the severity of illness and diagnoses are substantiated to ensure they are correct.

What has been the impact of PPS on rural health care?

Figures compiled through the IFMC's long-term care review system show that more patients are being transferred from hospitals to finish their recovery at lower levels of care provided by nursing homes. The swing bed program--in which hospitals are reimbursed at a lower rate for a less intensive level of care--is also growing and providing another alternative to acute care. According to the Iowa Hospital Association, more than 300 Iowa hospital beds were converted to lower levels of care last year. Since PPS began, only one hospital has closed and as the IFMC understands the situation, the closure was not due to any financial difficulties created by PPS, but rather due to a lack of medical staffing.

A pressing question that should be addressed, however, is whether alternative forms of care and lower levels of care are distributed equitably across Iowa. If a determination is made that a patient no longer needs acute care, but is still in need of medical assistance, what resources are available in the community? Strides are being made through home health care and other means to provide for this "step down" level of care. Although the IFMC has no definitive figures on this issue, it is one that should be addressed for Iowa and on a national level. The other question to be answered in this regard is whether all rural hospitals can survive by providing only medically necessary care that meets the critical review standards now in effect.

Should there be consumer representation on PRO boards?

The IFMC presently has representation on its board from a variety of groups and interests and welcomes the suggestion of adding a consumer representative. The IFMC is a very careful and deliberate organization and proud of the job we have done. We have a very elaborate internal monitoring system that involves more than 140 physicians who sit on committees whose sole purpose is to judge the accuracy of reviews so that we can continue to perform our mandated task well.

IFMC
**Iowa Foundation
for Medical Care**
Colony Park
3737 Woodland Avenue, Suite 500
West Des Moines, Iowa 50265
515-223-2900

July 30, 1985

Ben Gruber, Project Officer
Division of Health Standards & Quality
Region VII
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Contract No.: 500-84-0513
Correspondence No.: 85-51
Topic: Information Requested on PRO Quality of Care Assessment
and Corrective Action

Dear Ben:

We have several mechanisms by which we monitor quality of care and identify areas of concern.

All reviews conducted by IFMC include a quality component. Our worksheets specifically request a response concerning the quality of care. Cases may be identified for further review by our Quality Assessment Committee. Cases may be referred by IFMC review staff or by physician's reviewing for us. Following committee review, an educational letter is directed to the physician responsible for the questionable care.

All readmissions within seven calendar days are reviewed for the possibility of the occurrence of a premature discharge. If reviewing physician determines that the second hospitalization was the result of premature discharge during the first hospitalization, or that the patient could have been cared for during one hospitalization, an educational letter is sent. This letter includes the rationale of the reviewing physician. Thus far, 413 premature discharges have been identified.

A second premature discharge will result in a case presentation to the IFMC Comprehensive Review Committee with a recommendation for predischarge screening. The predischarge review requirement is in effect for three months. Discharge cannot be prevented and no denials are issued. The review is educational. Thus far, two physicians have been placed on predischarge review.

IFMC staff are also acutely aware of the concerns of Medicare beneficiaries and their families. We follow up on phone calls and letters concerning difficulties experienced by Medicare beneficiaries. Our first step is to determine IFMC involvement in any reviews or denials. Whether or not we were involved in a case, we make every effort to clarify or resolve the problem.

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We have recently assessed several situations where family members felt that a Medicare beneficiary was denied access to acute hospital care or was discharged too soon from an acute hospital. In these cases, we assisted family members in attempting to address the issue, despite the fact that IFMC was never contacted to review the cases. (The providers and practitioners told patients that Medicare would not pay even though no review had occurred by the PRO without obtaining review from the PRO.)

As always, the quality of care provided in Iowa is of genuine concern to us.

Sincerely,

Fred Ferree /lk

Fred Ferree
Executive Vice President

FF:lkj

Senator GRASSLEY. Thank you, Doctor.

Mr. PIETZSCH. Thank you, Senator Grassley. I want to thank you and the committee for holding this hearing in Iowa on Medicare prospective payment system. I also want to take this opportunity to thank your staff, Paula Dierenfield, Sara Thomasson, Ted Totman and Whythe Willey, for their assistance in this effort, as well as other important health issues in Iowa.

As you know, health is becoming a major interest not only to health professionals, but also to payers of health care and Iowa citizens. We look forward to the leadership of the Congress and our representatives in Congress.

As stated, I'm Paul Pietzsch, president of the HPCI. Our organization was formed about 3 years ago by the leadership in this State. We are a private, nonprofit corporation and a designated health planning organization. Our mission is to foster access to quality health care at a more appropriate affordable price. This certainly is a challenging goal not one that we all share in the State of Iowa. Our broad-based board consists of representatives of all sectors of the State—business, labor, consumers, hospitals, physicians, nurses, State and local governments, insurers, and so forth.

I will keep my remarks short. First, our organization is generally supportive of the major reform that occurred with the creation of the prospective payment system by Medicare. The perverse incentives of the old inflationary cost-based system were finally dismantled by this new system.

I would also add that it is clear that the health care system does respond to incentives. The PPS is an initial step in moving toward a more competitive market-oriented system we hoped for.

As I stated, the system clearly responds to incentives. Let me cite a few examples:

Data from the Iowa Hospital Association indicate, comparing 1983 to 1984, the following:

First, total hospital expenses in Iowa were down 3.5 percent.

Second, hospital margins are up.

Third, contractual allowances are down.

Lastly, at the same time, admissions for the 65 and over population were down 11 percent, and patient days are down almost 20 percent. The average length of stay for Medicare patients is down almost 2 days.

Data from the Blue Cross of Iowa, which is the Medicare fiscal intermediary for most of Iowa, suggest that in the last half of 1984, hospitals on DRG's were paid on the average 101 percent of billed charges.

The program is also causing a major restructuring in the health care organizations in Iowa. Generally speaking, this is very positive for the people being served, as well as all other parties. This includes an increase in outpatient care, in-home services, and other alternatives along the continuum of care. We are also seeing a greater integration of services; linkages and closer working relationships between hospitals, physicians, home health, long-term care and other providers. In general, this is also a positive trend that needs to continue and be expanded upon.

Thus, clearly, major changes are occurring, fundamental changes. Iowa physicians, hospitals, and their boards of directors and other providers are to be congratulated for the speed with which they are responding to the new incentives, and working to monitor the quality and access. They have seized the opportunity and the challenge, and they have made the tough budget decisions, rather than passing the costs on to the private sector. We hope and encourage Congress to appropriate sufficient funds in the future so that Medicare can, in aggregate, pay its fair share of the costs.

The major changes are also causing some trauma, clearly. The changes, I'm sure, are causing uncertainty and some trauma among the people being served. Also, hospitals are experiencing larger drops in use, and other hospitals are not doing well financially, as our averages suggested earlier. Some hospitals, in other words, are not doing nearly as well as the averages would indicate.

The problem is most acute in rural areas of Iowa, and is aggravated by the inequities of the Medicare prospective payment system. HPCI identified this problem in early 1984 and actively supported changes to these inequities. Senator Grassley, you and your colleagues in Iowa with the Iowa congressional delegation, have been instrumental in getting a revised wage index. Although this will help rural Iowa hospitals a little, it does not correct the basic problem, which is a problem in the law, although not in the original administration proposal. The creation of separate rural and urban payment schedules is the basic reason for the rural/urban payment differential—not the wage index.

Rural hospitals, both in Iowa and on average across the country, after adjusting for case mix and usage differentials, still had substantially lower base year costs than urban hospitals. It appears they were lower cost at the start of the program and were clearly put on a lower payment schedule. The creation of these separate payment schedules is at the roots of the rural/urban differential. We believe this payment differential could, in the long run, pose serious threats to accessibility of care in rural Iowa, and certainly in other States as well. We would urge Congress to proceed on schedule with the phasing in of national rates, and also to take the necessary legislative steps to correct any inequities in the urban/rural differential payment schedules. In this vein, we believe that measures of severity of illness within DRG's need to be developed.

HPCI has not taken a formal position on Senate bill 1376, although I believe we will be generally supportive of a new wage index. The old indices have been subject to so much debate and so many questions that a new wage index would seem to be in order. We will reserve judgment on the periodic adjustment called for in this bill, however. Without some further analysis on the incentives that would be created, we would be concerned that it might result in or be interpreted as a wage passthrough, which we would be concerned about.

I'm not sure what the intent of this portion of the bill might be.

The quality of care issue is a very complex one, as you know. Others on today's program will deal with this in more detail, but I would like to make the following observations:

One, quality of care is very difficult to measure.

Two, standards for adequate/optimal care are difficult, at best, to agree upon.

Three, only a limited amount of work has been done on measuring quality from an outcome standpoint. Most measures are rough proxies.

Four, little baseline data on quality has been captured.

Five, to a larger extent, both the general public and some providers believe the myth that more care is automatically better quality care, and conversely.

Six, the small area analysis of utilization in Iowa, using an approach developed by Dr. Wennberg at Dartmouth, has demonstrated wide variation in the rate at which people are hospitalized. No evidence has been found that people are getting better quality care in areas where people were hospitalized more frequently.

In light of these factors, a lot of uncertainty exists about the quality of care. We clearly need to invest more in measuring and monitoring the quality of care so that the real problems are identified, addressed, and alleviated. There is no consensus that quality of medical care is being compromised under the new prospective payment system. I think that most would agree that the amenities provided by hospitals have been reduced. Patients are spending more of their convalescent period at home or in other settings, rather than in the hospital. In this regard, we need to continue and would urge the continuation of building more adequate community and support programs.

In regard to your question about health services price data, the availability to the public of specific data on price, use, and quality, is and will remain a top priority of HPCI. Our close working relationship with the Iowa Health Data Commission and others has demonstrated that such information can be made available in a meaningful and responsible manner. We believe these efforts are making Iowa consumers better consumers, our purchasers better purchasers, and providers of health care better providers.

My final comments are directed toward the importance of Medicare moving toward a more capitated system of prospective payment. Capitated—per capita per year. This could be accomplished through increased enrollment of Medicare beneficiaries in HMO's and other forms of competitive medical plans. Experiments need to be undertaken in providing beneficiaries with vouchers and letting them purchase the best-value coverage. The publication of the final regulations for Medicare participation in HMO's and competitive health plans is an important first step. Progressive Iowa hospitals, physicians, and insurers are rapidly developing the necessary organizations to compete in such a market. Over the long haul, these entities will be better equipped and will have the incentives to determine the method and amount of payment to hospitals, physicians, home health agencies, and so forth.

In summary, we need to rely more on the market. The DRG system is a governmental price-fixing system, and over the long haul the Government is probably not the best entity to set prices.

I believe that this sort of thinking is behind Senator Grassley's thoughts regarding purchases by the Defense Department, to use more price determinations through competitive bidding, thus the market. The current DRG system is a transitory system. It should be fair and equitable and must be made to ensure that quality and access are maintained. Modifications are and will be needed to meet that objective. At the same time, as much, if not more, effort and attention should be drawn toward moving through this phase into a more market-oriented system.

Quality and accessibility of care at a price that society can afford is a goal that we all share. This hearing will help to meet that goal.

On behalf of the HPCI I want to again thank you, Senator Grassley, for this hearing. That will conclude my remarks and I would be happy to answer questions.

Senator **Grassley**. Before I go to questions, there's one other administrative thing that I should have said, and that's to everybody who's on a panel, but also anybody else, here or not here, who might be interested in speaking on this issue, even though you were not invited to be on a panel. I will leave open the record for 30 days. Normally it's just 15 days, but we'll make it 30 days this time, for anybody who wants to make an appropriate statement, assuming that it's not too long—and what you've heard so far would be entirely appropriate—that would be printed in the record as if stated here, as if you were invited, either in agreement or whatever point of view you want, on this subject.

Also for the benefit of those who are here and on the program, that also gives you an opportunity to add to any of the statements you leave, or to make any corrections or additions.

Now I have questions in the order in which you spoke, but my questions, for instance, to Mr. Fleming, if either of the other two—and the same for all of you—want to respond to those questions, if there's something you want to do along that line, don't feel inhibited just because I have asked the question of a specific person.

In the case of Mr. Fleming, you mentioned in your testimony that you're seeking input from Congress and other interested parties on their recommendations as to what new index should be selected to replace the current area wage index.

You know that I've introduced legislation to implement a new gross wage index and to waive retroactivity. How does this comport with comments that you have received in response to your solicitation in the Federal Register, and specifically does HCFA support my bill?

Mr. **Fleming**. As to the specific comments in the Federal Register, Senator, I'd be happy to supply it for the record, if you'd like.

The Secretary has stated that she is in favor of the HCFA gross wage index. She's also equally concerned about the retroactive aspect of it. So generally we certainly are not opposed to your suggestions that you have put forth in your bill.

Senator **Grassley**. But the Department does not specifically support the approach of my legislation at this point. It's just that——

Mr. **Fleming**. To the extent that we have recommended the HCFA gross wage index and have recommended that Congress consider repealing retroactivity, yes.

Senator **Grassley**. OK. Thank you.

The waiver of liability provides payment for uncovered services if the hospital maintains a rate of less than 2½ percent. Again, this is to you, Mr. Fleming. In February the agency issued a proposed rulemaking that would end that favorable presumption for providers. I'm sure that many hospitals have reacted negatively to such recommendations, and what does your agency intend to do with this now that you've had a chance to have these reactions?

Mr. **Fleming**. Mr. Chairman, as you know, we have not issued a final regulation, so it's still in the consideration stage. We are trying to address a problem of about $1 billion in overpayments a year, which is a considerable sum given the state the trust funds were in and our desire to be good fiduciaries, good stewards of that trust fund. Our desire is not to end the waiver of liability, but to ratchet downward the margin, if you will, of the favorable presumption so that where there is doubt, hospitals would—we would take a look at it case by case to see if that should be waived.

As I said, it's still in the consideration stage.

Senator **Grassley**. OK. In the event that Congress freezes DRG rates in fiscal year 1986—and it seemed to me like, with the budget being adopted on Thursday, that that's one of the approaches that's a very live approach for reaching our budget policy—does your agency favor the delay of transition to national DRG rates for 1 year? In other words, maintaining the 50/50 split between hospital-specific and national DRG rates?

Mr. **Fleming**. We have said that we should proceed with the transition as originally scheduled.

Senator **Grassley**. Should proceed as originally scheduled. OK.

Do you feel that the prospective payment system has increased the demand for post-acute care, and what is HCFA doing to help provide greater availability of Medicare post-acute services?

Mr. **Fleming**. Yes; we anticipated that as a result of prospective payment and the changes in the incentives that the length of stays would be declining and that people would be taking greater advantage of existing skilled nursing facilities and home health care.

Interestingly, the increase in utilization of skilled nursing facilities has not materialized to the extent that we had expected, but there has been considerable increase in the utilization of home health benefits. However, the Medicare benefit was always conceptualized to be an acute care benefit, not a long-term, post-acute care benefit. And so the home health benefit is somewhat limited, in that it's restricted to intermittent care and homebound.

Senator **Grassley**. I missed that point where you said what level of care didn't reach the——

Mr. **Fleming**. The skilled nursing facilities—the utilization of skilled nursing facilities has not increased.

Senator **Grassley**. And you anticipated 2 years ago that it would have increased?

Mr. **Fleming**. Well, we thought there would be increased utilization of skilled nursing facilities as well as home health care. But while the skilled nursing facilities utilization is up, it's not up to the extent we had anticipated.

Senator **Grassley**. Is that of particular concern to HCFA?

Mr. **Fleming**. No; it indicates, I think, that people, when they're released from the hospital, primarily want to go home and be at home, where possible. The skilled nursing facilities are still a fairly extensive form of treatment, and treatment at home offers an opportunity to be in familiar surroundings, if the patient's condition permits a less extensive form of treatment.

Senator GRASSLEY. Dr. Davis testified before the Senate Finance Committee just last week that HCFA could not come up with a responsible proposal to adjust DRG's to compensate hospitals who served disproportionately—a disproportionate share of low-income patients. I have to admit that I have concerns about such a proposal, because to keep the budget neutral it would probably come out of the hides of rural hospitals, and so I'd like to have you review the difficulties HCFA has had in analyzing this disproportionate health care.

Mr. FLEMING. It has been an extremely difficult problem to get a handle on. Medicare itself pays for Medicare benefits. It is not set up to be a payment that includes prorated portions of uncompensated care in hospitals, yet we recognize it is a problem for hospitals as well. We are under court order to provide in the 1986 rate, however, a statement dealing with disproportionate share, and we are busy at work on that right now and should have some language for the notice of proposed rulemaking next year.

Senator GRASSLEY. So that can be handled by regulation, as opposed to by statute.

Mr. FLEMING. We're going to address how we're going to handle it by regulation. We, to this date, do not have—I cannot give you an answer as to how that's going to materialize.

Senator GRASSLEY. Dr. Mandsager, the professional review organization reviewing rural hospitals has identified a number of cases which don't meet medical necessity criteria for inpatient admission. How many of these can be attributed to the absence in rural areas of alternative health care facilities that could provide services on an outpatient basis? And before you answer that, could I say also another question going along with it: Do you find that services previously provided on an inpatient basis near the patient's home now have to be done in an outpatient facility located a considerable distance away?

Dr. MANDSAGER. No, I do not think so. I think that in the instances where it is either almost mandated or necessary for a procedure to be done in an outpatient facility, nearly all of the small rural hospitals have set up arrangements so that their patients can be cared for not in a freestanding outpatient facility, but within the confines of that local rural hospital. In other words, as an example, we don't have a freestanding facility in our local community, but we are finding today that about 50 percent of our surgery is being done as outpatients within the walls of the present hospital. And I think that's true of practically all rural hospitals. They have either designated a certain area of a hospital as an outpatient area, or they have made arrangements through their emergency rooms, et cetera, to manage the patients on an outpatient basis.

Senator GRASSLEY. Do current regulations still require that a letter of denial be sent to the patient, even if the charges are to be paid under the hospital's waiver of liability, which, of course, causes confusion and concern among beneficiaries? And I'd like to have you elaborate on your organization's concern with this regulation. I know you spoke to it somewhat in your statement. And I'm going to ask Mr. Fleming to respond to your suggestion to modify this regulation, if you have such a suggestion.

Dr. **Mandsager**. Yes; we do feel that where there is no payment consequence, that the mandated regulations that say that we must notify the patient of the denial is causing great consternation, on the part of the elderly, particularly. They do not understand why the denial took place, and yet they don't have—it isn't costing them anything. What is this? And for many of our elderly, this is of great concern.

Another area that has caused us great concern is in the cases of where some services have been denied and the patient is actually deceased, and the patient's family must be notified of this denial. And, again, in their grief processes and so on, this causes a great concern.

We feel that the regulations—or actually the law—should be changed so that we do not have to provide a letter of denial to the patient or family, as the case may be, where there is no payment consequence.

Senator **Grassley**. Mr. Fleming, could you respond to that, please?

Mr. **Fleming**. Well, conceptually, I wouldn't have a problem with that. As I said, no final decision has been made as to the final regulation. That is still in the discussion stage.

Senator **Grassley**. Has there been lots of comments received on it, generally of the point of view expressed by the Iowa doctor here?

Mr. **Fleming**. Again, we could supply that for the record, if you wish.

Senator **Grassley**. Do you have any appreciation, off the top of your head—is the evidence you've gotten fairly weighty in support of the repeal of the regulation or the changing of the regulation?

Mr. **Fleming**. I haven't seen it.

Senator **Grassley**. OK.

Mr. **Fleming**. It would be, we suspect, hospitals and industries are opposed to the repeal of the favorable presumption.

Dr. **Mandsager**. But as to changing the law to if the waiver of liability continues to exist as is now, would there be opposition? Do you feel that the evidence that has been garnered to date would support our position?

Mr. **Fleming**. On making notification? Sure.

Dr. **Mandsager**. That it makes no sense to notify these people if there is no payment consequence?

Senator **Grassley**. There seems to be a weighty body of evidence, plus some agreement within the bureaucracy, then, on that point?

Mr. **Fleming**. Yes, sir.

Senator **Grassley**. Will it be a long time, do you think, before—I mean like 60 days, 90 days, or——

Mr. **Fleming**. Oh, it would be at least that. They're in the midst of a transition to a new Administrator, and I'm sure whoever comes in is going to want the chance to look at it.

Senator **Grassley**. Once again, Doctor, the Iowa peer review organization is, of course, unique in that local peer review and local physicians are in the same hospitals and are willing and capable to review each other. I think since it is fairly unique, I'd like to have for the record your feeling on the advantage of that, even if there might be some people here who would disagree with you. I'd still like to have you tell us how it works.

Dr. **Mandsager**. We strongly support the viewpoint that peer review should be by our peers, and we do feel strongly that by the use of physicians locally, these physicians are in a better position to understand and to better judge the situation than somebody from a distance of, say, 300 miles or 400 miles, as the case may be. Again, from my perspective, I think that the consumers, the patients themselves, feel that if they're being reviewed by the peers of their community, that they will be given a more fair consideration. I do not think that this has resulted in overutilization. I do not think that, generally speaking, we are showing favoritism to our peers. I think in many instances it's surprising how the local peers will wield the ax, so to speak, on their fellow peers within the community.

By and large, I think that we do feel that peer review should be by peers within the area.

Senator **Grassley**. If a beneficiary's admission is later determined not to be medically necessary, in what circumstance is the patient responsible for paying those charges?

Dr. **Mandsager**. Only would they become responsible in the case where a denial of necessity of staying in the hospital over and beyond the time that the physician feels necessary. For example, if a patient decides that they would like to be in the hospital for some additional time, and the physician who is caring for that patient decides that it is no longer necessary, or the hospital—surely, under the prospective payment system it's for the hospital's benefit that the client leave the hospital in the shortest time possible, if, under those circumstances, a denial of continued services is granted by the peer review organization and the patient still elects to remain in the hospital, from 72 hours after that original denial has taken place, they are responsible for paying that bill.

Senator **Grassley**. How often does that happen, do you think; very often?

Dr. **Mandsager**. Very, very rarely.

Senator **Grassley**. Do you have any figures that might indicate how much it happens?

Dr. **Mandsager**. No, I don't.

Senator **Grassley**. You don't think you have anything, not even for submission as part of the record?

Dr. **Mandsager**. No; I would think it would be far less than 1 percent. It's in the tenths of 1 percentage point, I think. It's extremely low. Generally speaking, it's my experience that when patients become advised that the bill is their total responsibility from that time on, they either make arrangements for a lesser care facility or for caring for themselves at home.

Senator **Grassley**. Do supplemental health benefit policies that most Medicare beneficiaries carry cover these situations?

Dr. **Mandsager**. Generally speaking, no. It would be my feeling—I know that, for example, Blue Cross/Blue Shield pay only for those services that are approved by Medicare. They will assume their share according to the policy, but only approved Medicare services

Mr. **Fleming**. I think that's true of the medi-gap policies also.

Senator GRASSLEY. When the peer review organization's contract with HCFA was set, reduction goals for certain medical procedures were a part of it against which they evaluated the new contracts. Where do you derive these goals to lower the numbers of procedures, admissions, and patient days of care?

Dr. MANDSAGER. Well, our goals were determined largely by statistics that we had garnered over the years in our data processing, where we had determined that we felt that there was opportunity for reductions. And it was largely through our data services that we obtained our goals, or came up with our goals.

Senator GRASSLEY. So, historical facts?

Dr. MANDSAGER. Yes.

Senator GRASSLEY. Mr. Pietzsch, there has been continuing debate in Congress on the advisability of providing specific service data on hospital use and physician charges. Where is your corporation in its efforts to generate this data, and how can you assure that it is made available in a meaningful and responsible way, if you decide to go that direction—or have you decided to go that direction?

Mr. PIETZSCH. As you know, we're working with the Iowa Health Data Commission, which is a commission established by the State legislature 2 years ago. And right now, the data commission has published reports by individual hospitals. They have not yet published reports by individual physicians. That is in their work program, calling for it in a year or so.

The reports so far that have been published by individual hospitals have been mainly on charges for individual procedures, the 25 most frequent procedures for each hospital. They are also now looking at the second part of the equation, which is use or utilization. And the third part of the equation, the final part, is quality, which is down the road a ways.

So the goal is to publish, by individual hospitals and individual physicians, down the road, data specific to each hospital and each doctor on price, utilization, and quality of care. And so far, as I've indicated, they've published it by individual hospital on price, and are moving on into those other areas along the time frame that was established by the data commission.

Senator GRASSLEY. Do you have hospital- and physician-specific data from the Medicare Program?

Mr. PIETZSCH. We have hospital-specific data. We cannot, under the current rules, get physician-specific data for Medicare.

Senator GRASSLEY. You pointed out the fallacies of basing reimbursement decisions largely on geography. Do you feel that the rural/urban differential under prospective payment should be eliminated?

Mr. PIETZSCH. Yes; I think there's a better way of doing it. It seems to me geography doesn't make a lot of sense. Clearly, when the program was being developed, they were looking for data like past charges of hospitals, and there were differences that came up—that more or less paralleled geographical lines. But to me, a primary care hospital in an urban area receiving 20–25 percent more than a primary care hospital in a rural area, doesn't make a lot of logical sense, and that's the estimates we're seeing. We think there are probably some adjustments that need to be made along the severity of illness lines, but that should not be geographic; that should be along those lines.

Senator **Grassley**. Could you elaborate on your suggestion to move toward a capitation system of reimbursement under Medicare?

Mr. **Pietzsch**. Yes, capitation is the word in the literature, so I used it. But we're talking about payment per person per year for health services, and it does have a lot of merit in the fact that it gives the provider and the consumer the flexibility to provide and receive the appropriate level of care in the appropriate setting. And it does seem to have merit. In the regulations that were recently published by Medicare, a program is set up using the voucher system and the HMO, really what you'd call a competitive medical plan option, for people to move toward. We encourage that, and we also call in the testimony for some experimentation in that regard.

I believe in Iowa that physicians, hospitals, and others are responding and will be in a position to provide that kind of option for Medicare in the near future.

Senator **Grassley**. You know, we hear—it's even been discussed here today—about patients being discharged in the rural communities where appropriate followup care may not be available.

As an agency that's involved in statewide health care planning, can you tell us what is being done in Iowa to address this problem?

Mr. **Pietzsch**. I think, clearly, when Medicare prospective payment came on line with a fairly short leadtime, and people weren't sure it was even going to happen, that there probably weren't the programs, the alternatives, in place that needed to be in place. There's been catching up to do since that time, and there still is a reshaping of the system underway—and not only in rural areas, but also in urban areas—in terms of providing alternatives. And there's still a lot more work to be done in this area.

Also, we've been supporting the Governor's task force on long-term care which has been looking at the long-range policy directions in Iowa. There is a close tie between rural health care and long-term care, because a lot of people in rural Iowa tend to be elderly folks and they need more health services.

So I think we've had some catching up to do. The payment system came in place in a relatively short period of time without a lot of warning; at least people weren't sure it was going to occur. And there has been a lot of action toward providing the alternatives and developing those alternatives, but I think we still have quite a ways to go in that area, in terms of reshaping and providing the alternatives, not only nursing kinds of care, skilled nursing, and so forth, but also in-home services, day care centers, and other programs along a continuum care approach.

Senator **Grassley**. Before I thank you and call the next panel, do any of you have any last statement you want to make?

Mr. **Fleming**. Can I come back to one of your questions, lest I put words in the mouths of people who don't like to have words put in their mouths?

Senator **Grassley**. Those would be people above you, I suppose?

Mr. **Fleming**. Yes. You asked about the HCFA gross wage and preferences, and I want to make sure that we're clear that that final reg has not been issued. No final decision has been made on that. While HCFA developed that, and we think it's a very good wage index, we are still looking for the input. As we said in the statement, as Secretary Heckler said in a letter to Congressman Rostenkowski a week or so ago, we're looking at all of those combinations. But no final decision has been made.

Senator GRASSLEY. But there's not even a proposed reg for comment at this point, I assume?

Mr. FLEMING. That's correct.

Senator GRASSLEY. Doctor, anything you want to say in closing?

Dr. MANDSAGER. My only closing comment would be that as a physician-based peer review organization, our big concern is going to be that we maintain quality and availability of services. And I think that we will do all within our power to maintain that. These things can be maintained in the State of Iowa.

Senator GRASSLEY. Mr. Pietzsch.

Mr. PIETZSCH. The last point I would make is that access and quality are very important, and we need to maintain those as high priorities.

In that regard, I would indicate that I think we need to do as much as possible to help communities and the providers in those communities in the reshaping process that they're having to go through because of the fundamental changes in payment incentives; not only Medicare, but in Iowa, Blue Cross has changed their payment system, and Medicaid, and so forth, and that reshaping is very fundamental and very difficult. So I think we need to provide a lot of support to communities and providers in the communities to do that, so that we do maintain quality and access.

My other point is there is still an inequity in the payment system under Medicare. We believe it's fundamentally because of the difference in the payment schedule, one for urban hositals and one for rural hospitals. We encourage that it be corrected along the lines outlined in my remarks.

Senator GRASSLEY. Thanks to each of you, and continue to let us hear your views as we move toward trying to solve—hopefully solve these problems that are presented here today.

Now I'm going to call our next panel, and if you'll come while I'm introducing you, first of all, we have Martha Williams, who is senior vice president of the Iowa Hospital Association, and our second witness is Dr. Dennis Walter of Des Moines, and he is a family physician and chairman of the board of trustees of the Iowa Medical Society.

So if you two would come together.

I'd like to also suggest that Ms. Williams will discuss the impact that the prospective payment system has had on our hospitals and on access to care. The Iowa Hospital Association has been very helpful to my office over the last 2 years to pinpoint problems with this new reimbursement method. We're happy to have you here, too, Dr. Walter, and we look forward to your comments on the impact that the prospective payment system has on physicians and beneficiaries. And let me say it for you, because you may not want to say it, on your ability to practice medicine and to serve the responsible role that physicians have to serve in their society.

I think I'll have you go in the order in which I introduced you.

STATEMENT OF MARTHA WILLIAMS, SENIOR VICE PRESIDENT, IOWA HOSPITAL ASSOCIATION, AND DENNIS WALTER, M.D., CHAIRMAN OF THE BOARD OF DIRECTORS, IOWA MEDICAL SOCIETY

Ms. WILLIAMS. Thank you, Senator Grassley.

The Iowa Hospital Association, which represents all of the not-for-profit and publicly owned hospitals of Iowa, appreciates the opportunity to present its views on Medicare's prospective payment system's implementation in Iowa and its implications for Iowa and the older American network.

Health care in Iowa is based on quality. While the word "quality" defies precise definition in health care, it is generally viewed as that effort which is characterized by a combination of excellence, skill, knowledge, and understanding that those needing health care services are seeking and expect to receive. Hospitals in Iowa are committed to the dual mission of accessibility and quality of care.

It is uncertain if the quality of care now existent in Iowa can be maintained under PPS. Frankly, if overzealous cost containment measures go much further, quality may suffer in our Iowa hospitals. During 1984 and through May 1985, Iowa hospitals reduced their number of beds by 10 percent, and personnel by 14 percent. Admissions dropped by 19 percent, while admissions for patients 65 and over have dropped by 22 percent. Patient days are down 25 percent, and days for patients over 65 have decreased by 34 percent.

Medicare, through the Professional Review Organization, is enforcing stricter rules on how sick a patient has to be to be admitted to a hospital. Physicians no longer independently set admission standards as they have in the past. Likewise, hospitals cannot and do not set admission standards. Now insurance companies, including the Federal Medicare Program, indirectly establish admission standards by deciding what care will be reimbursed and in what setting. Yet, I would like to assure you that no Iowa hospital has yet to turn away a person whose physician deems hospital care necessary.

Medicare's swing bed program has allowed small rural hospitals to respond to a changing pattern of medical practice using existing hospital resources, and to meet an unmet need. The swing bed program has enhanced the local community hospital's ability to provide cost effective acute and skilled nursing care. It has allowed small hospitals to expand their revenue base and service portfolio, while utilizing existing resources, which means cost-effective care, both at the acute and skilled levels. Without Medicare's swing bed program, a gap in the continuum of care would exist in Iowa. In fact, we strongly believe the 50-bed ceiling should be relaxed and it would improve the quality and the availability of skilled nursing care. Any hospital, regardless of size or location, should be allowed to participate in Medicare's swing bed program.

The Iowa Hospital Association knows of no instance of failure to serve indigent patients.

All Iowa hospitals do provide substantial amounts of uncompensated care. In 1983, over $85 million of charity care and bad debts were provided. Additionally, the State's 43 county hospitals also use county tax funds to provide care to residents. During 1984, the uncompensated care increased to $90 million. The increase in the number of bad debts and charity cases has been dramatic in the weakened State economy with high unemployment during the last 2 years.

Rural hospitals cannot survive with their decreasing volume of services when their PPS payments for those same services are about 50 percent of that paid to an urban hospital for the same DRG. When 50 to 70 percent of the rural hospital patient volume are Medicare beneficiaries, there is not a sufficient non-Medicare patient volume with which to shift cost shortfalls.

There is a particularly inequitable problem for Iowa's "urban" rural hospitals serving as secondary referral hospitals, but being reimbursed at rural rates. Some adjustments have been made for qualifying regional referral hospitals, yet the large differentials still exist.

We strongly urge the adoption of a revised survey-based wage index as opposed to the inaccurate Bureau of Labor Statistics data currently being used. While the Iowa Hospital Association previously endorsed the use of the adjusted gross wage index retroactive to October 1, 1983, in order to ensure correction, we do support your bill, Senator Grassley, Senate bill S. 1376.

We strongly disagree with HCFA's proposed freeze on hospital rates now endorsed by Congress. Iowa hospitals, particularly rural hospitals, are already receiving less Medicare reimbursement than cost of care delivered to those patients. Not to at least recognize the inflation factor over the past year is unconscionable.

The concept of waiver of liability was established in the Social Security Act to protect providers and beneficiaries from undue financial liability for the provision of services which are determined after the fact to be medically unreasonable or unnecessary or custodial in nature and, therefore, not covered by Medicare. The waiver hinges on the question of provider knowledge that services are not covered. Presently providers are granted favorable presumption that results in a waiver of liability so long as certain administrative criteria are satisfied by the provider. Proposed rules by HCFA seek to remove the favorable presumption.

The waiver of liability rule goes to the heart of the issue surrounding quality of judgments by individual practitioners. The proposed rule was not developed because the present system was witnessing bad medical care decisions. Rather, the rule was a response to GAO recommendations that waiver criteria be tightened to achieve further cost savings.

Good medical care mandates that independent judgment be exercised based on what is best for the patient. The proposed rule is symptomatic of a governmental trend toward massive regulation and administration in the name of cost savings, and away from focus on patient care needs and services.

Providers must err on the side of giving care. A government truly committed to provision of medical services to its elderly and others must be willing to err on the same side.

Pressed by Government deficits, it is likely that the ideal goal of equal health care for all will be abandoned and a two-tiered system become a reality. Many Medicare beneficiaries hold several insurance policies because their expenses are not fully covered by Medicare. This multiple coverage is likely to increase as the elderly may have fears that they no longer have medical coverage. With Government denying admissions and refusing coverage, they have great concern for whether there is coverage available to them.

The Older Americans Act funded local area agencies on aging to serve as catalysts in communities and encourage the development of services. Previously, Medicare cost reimbursement restrictions on hospital accounting were detrimental to the development of many community-based services thought to be important by these agencies. Now, under PPS, there are more incentives today for hospitals to offer these services and most hospitals are working with community groups to integrate and coordinate these programs.

I would like to close by saying that we believe that Iowa has one of the finest systems of health care delivery in the United States. Nowhere is any resident more than 30 miles from a hospital, and the number of high-technology services offered in the rural setting is increasing. Iowa hospitals care about the quality of health care delivered to their citizens, but the Medicare payment system and the PRO regulations challenge the viability and existence of medical services delivery in this primarily rural State.

Thank you.

Senator **Grassley**. Thank you.

Dr. **Walter**. I am Dennis Walter, a family physician associated with Broadlawns Residency Program here in Des Moines, IA, and also chairman of the IMS Board of Trustees.

Senator **Grassley**. The first residency program in the State, too.

Dr. **Walter**. Yes. Thank you. Thanks to Lon Parker.

It is my privilege to represent the views of the Iowa Medical Society to you today with respect to the effect of the Medicare prospective payment system on older Iowans.

You have asked that panelists answer a number of questions, and I will attempt to do this.

The question of whether quality of care is being maintained in Iowa under the new prospective payment system is a subjective one. The Iowa Foundation for Medical Care, the PRO for Iowa, works closely with Iowa physicians and the Iowa Medical Society to assure quality of care is provided to Medicare beneficiaries. However, we believe that directives given to the foundation by the Health Care Financing Administration should place more emphasis on ensuring that Medicare patients receive all medically necessary services.

We are very concerned about provisions in the PRO contract with the foundation that establishes objectives of reducing specified types of services, including admissions, by a specified amount. We recognize that HCFA has stated that PRO contract objectives are intended to be goals rather than quotas. However, in practice these objectives have the undeniable effect of encouraging a PRO to deny appropriate as well as inappropriate admissions in order to meet contract objectives. We are confident the foundation will resist this negative incentive. However, if contract objectives are not met, the foundation risks losing its PRO contract to an organization that will meet the arbitrary objectives set by HCFA.

Some physicians are concerned about foundation activities as they relate to the Medicare prospective payment system. However, we are fortunate to be able to channel these concerns through a provider advisory committee of the foundation, which includes representatives of the IMS, Iowa Hospital Association, Iowa Osteopathic Medical Association, and the Iowa Health Care Association.

We are not aware of any inordinate problems with delays in admissions or premature discharges among Medicare patients, but feel the foundation could better assist you in answering this question.

Physicians are most interested in practicing medicine, and preadmission and preprocedure screening requirements are nearly always an obstacle and a delay. The desire to avoid being placed on a focus list also presents difficult dilemmas, particularly when the physician is unable to determine if an admission will be denied or approved, despite the fact his or her best medical judgment indicates hospitalization is needed. I feel, and we feel this is another case where Federal mandates have created incentives to deny care based on financial considerations, and not on what is best for the elderly patient. We believe the majority of physicians continue to keep the patient's welfare foremost in their thinking despite the risk of being placed on a focus list, which can occur with as few as two denials in a calendar quarter.

The proposed elimination of the waiver of liability by HCFA represents a radical departure from the historical relationship between Medicare and Medicare providers, and is of significant concern to physicians. It holds the potential of having a chilling effect on the ability of physicians to exercise their best medical judgment on behalf of patients. The practice of medicine is not an exact science, and physicians and hospitals should not be held financially responsible for services which were provided in good faith but are later found to be unnecessary in the opinion of the PRO. This is yet another incentive to withhold treatment on the basis of financial considerations rather than what is best for the patient.

To our knowledge, no indigent patients are being bumped among hospitals in Iowa. We believe this is a credit to Iowa's nonprofit, public and religious affiliated hospitals and Iowans generally.

We believe Iowa physicians have and will continue to care for indigent patients, either through Medicaid or for no charge at all. Physicians continue also to respond favorably to calls from the American Medical Association, the Iowa Medical Society and their county medical societies to discuss fees with their patients and to make adjustments for those unable or less able to pay. This is particularly true among Medicare beneficiaries where many physicians are willing to accept assignment if the patient indicates he or she is unable to pay the usual fee. Unfortunately, hospitals are less able to make such adjustments, particularly if high percentages of indigent or Medicare patients are cared for in these facilities.

As you know, Senator Grassley, rural hospitals are increasingly vulnerable to financial pressures. This problem has been made even more difficult by the Federal Government's prospective payment system, which pays hospitals on the basis of diagnostic-related groups. Small rural hospitals are placed at greater economic risk under the prospective payment system because they are not large enough to spread the risk of long-stay or resource-intensive cases.

This system, as implemented by HCFA, also discriminates against rural hospitals in granting adequate reimbursement for labor and supply costs. We appreciate your assistance in helping us make our case on this issue of critical importance to rural hospitals. We understand that HCFA has proposed a freeze on hospital and physician reimbursement for services provided Medicare beneficiaries. The imposition of this freeze would be particularly damaging to the quality of rural health care services where many of our elderly receive their care.

We have heard that some Iowa hospitals are in danger of closing because of pressures created in part by the PPS. The Iowa Hospital Association is the most appropriate organization to comment on this question. However, the viability of our rural hospital system is essential to assuring that physicians continue to serve rural Iowans. Without accessibility to hospital services, rural physicians will have little choice but to move their practices to larger communities.

At this time the Iowa Medical Society has no position with respect to your legislation to implement a new gross area wage index. However, we believe a hospital wage index should accurately reflect the actual experiences of an individual hospital. For example, in determining a labor adjustment for a hospital located in a rural area, HCFA should consider whether that hospital must compete for employees in an urban area. Different wages paid in inner-city hospitals, suburban hospitals, outlying hospitals, and truly rural hospitals should be utilized as an accurate adjustment figure that would reflect experience as opposed to an average.

Just as we have continuing concerns over the hospital DRG payment program, we have even stronger concerns over the DRG-based physician payment program. A DRG system inherently gives substantial incentives to provide minimal care. It also fails to take into account severity of illness. This is especially troublesome for those physicians who, because of specialized skill and training, see patients with the most severe illnesses. Since the DRG methodology is based on averages and, unlike hospitals, individual physicians do not ordinarily have a large enough patient population with identical diagnoses to enable costs to be spread over a larger base, a DRG system would operate as a disincentive for physicians to accept critically ill Medicare patients and would discourage necessary use of consultants.

We are also concerned about a program where all services to hospitals' inpatients would be based on DRG's and payment would be made through the hospital. It is evident that if both hospital and physician payments are based on a predetermined amount, all the economic incentives will be strongly directed toward underprovision of care.

Perhaps the most serious drawback to a DRG-based payment system is that it would break down the role of the physician as the health care advocate for the patient. We never want to see the day when the "best" physician, as designated by Medicare, would be said to be the one who was the least expensive as opposed to the one who provided the best care. Because of its strong potential for adverse effects on patient care, we would object to a DRG system in the absence of proven demonstrations that it assures quality of care.

You may know that the American Medical Association is actively pursuing the development of a relative value study to establish resource cost based relative values for physician services. A reimbursement system based on a resource cost based relative value study could ameliorate problems inherent in current Medicare reimbursement, and it would allow for greater competition among physicians by allowing patients a greater understanding of charges made for each service. Such a system would also address inequities in payment rates for services that are predominantly cognitive in nature.

In closing, we suggest that you continue to closely scrutinize the effects of the prospective payment system. You may be aware that the AMA is continuing to monitor the effects of the PPS through its DRG monitoring project and through the use of surveys. In addition, the association is currently working in conjunction with Johns Hopkins University to develop a series of research proposals which result in a multifaceted study of the long-term effects of the prospective payment system on the quality of health care for Medicare beneficiaries. I am sure the American Medical Association will be pleased to keep you informed of these research activities.

Thank you.

Senator **Grassley**. Thank you very much, Doctor.

Again, I have questions of each of you separately, but as in the case of the previous panel, if one would like to respond to a question that I ask another, feel free to put in your expertise, because we don't want to leave anything out just because I might not think of you as having a point of view on it.

My first question is a series of reactions you have, Ms. Williams, to the fact that the House Ways and Means Committee has finished marking up its reconciliation package, and it contains a number of prospective payment system provisions that would affect Iowa hospitals, just like every other hospital, I suppose. So I'd like to have your response to this: Whether or not you favor adjusting DRG rates to provide additional payments to hospitals serving a disproportionate share of low-income patients, and whether that's a particular problem for some Iowa hospitals.

Ms. **Williams**. My answer to that, of course, is that I am in favor of the Federal Government alleviating those programs that are doing a high percentage of charity care. However, again, it's structured for the urban hospital in the large areas. It does nothing for the small hospitals in Iowa who have a large percentage, a disproportionate share.

Again, they estimate there may be five urban hospitals in Iowa that might possibly qualify for that.

Senator **Grassley**. You're saying that there are many more hospitals——

Ms. **Williams**. That's right.

Senator **Grassley** [continuing]. That have a disproportionate share of low-income patients?

Ms. **Williams**. That is correct.

Senator **Grassley**. Would you have a figure on what percentage of the total number of hospitals beyond those five might come under that designation, just even if it was a rough guess?

Ms. **Williams**. I was talking to a couple of our small hospital administrators. I saw two or three of them just recently at a meeting where this was being discussed. I believe it was one of your comrades on the House Ways and Means Committee who was speaking at a small hospital breakfast in Chicago. And those two administrators, just like that, said, "I could qualify easily."

Now, we haven't had time to do any kind of a survey. I just quote that as an anecdotal source.

Senator **Grassley**. What impact would the delay of the transition of the national DRG rates have on our Iowa hospitals?

Ms. **Williams**. Senator, it would be mixed. Our Iowa Hospital Association Board did take a position a couple of months ago to continue the transition to the national rates. However, I tell you that that's not a unanimous support by all hospitals. Things are getting divisive nowadays. As we look at our information and our statistics, there probably would be more hospitals that would be better under the national rates as it gets away from the hospital-specific. But that's certainly not true of all hospitals in Iowa.

Senator **Grassley**. I want to preface my next question by saying that I appreciate your organization's support of my bill which would implement the new gross area wage index, and you probably know that I've had to reluctantly, because of political reality, face the fact that retroactivity must be waived in an adjustment to the new wage index.

Ms. **Williams**. Right.

Senator **Grassley**. Does your membership understand and support the waiver of retroactivity because of the dislocation that it would create for overpaid hospitals?

Ms. **Williams**. Well, I think we looked at it as "What's fair is fair." And those hospitals that have been overpaid should take some of the burden to relieve the suffering of those hospitals that have been underpaid, such as our rural hospitals in Iowa. They have hung on, they have existed, and in order to get correction, they are willing to give up the retroactivity. But I'd say that it's based more on the fact of future area wage index that's more adequate.

Senator **Grassley**. I just want to make it clear that I recognize that the wage index correction is but one of the many inequities that need to be addressed to put rural hospitals on the same footing as urban hospitals.

Ms. **Williams**. The nonlabor component is even more onerous. It's just more difficult to collect accurate information on.

Senator **Grassley**. In our region it is my understanding that the standardized labor reimbursement is 25 percent higher for urban areas than for rural areas. Furthermore, the standardized nonlabor reimbursement is 54 percent higher for urban than rural areas. And, of course, that just doesn't seem to make sense to me, but would you have any reason for this differential?

Ms. **Williams**. We don't understand it, either, Senator.

Senator **Grassley**. That makes it kind of difficult to make a policy decision.

It is also my understanding that one of our hospitals in Lake City compared its reimbursement for several DRG's with two hospitals in the metropolitan statistical areas on either side, and found a difference of over 100 percent. What kind of implications do such disparities have for hospitals in the long term?

Ms. **Williams**. That was an illustration of specific DRG's. They might compare some other DRG's and find that it had a lot less disparity. I think, as we have averaged it out, it's about 54 percent.

The point they are making is, it's the same service, it's the same DRG, it's not a sophisticated service done in another hospital that they are performing. And it is illustrative of the fact that that same service, it's ridiculous to expect that the hospital in Lake City can do it for 54 percent of the reimbursement of a nearby urban hospital.

Senator **Grassley**. Rural hospitals in the States of Iowa, Nebraska, and Kansas are expecting to lose $36 million under the flawed reimbursement methodology this year. Is this a realistic projection, and do you have any figures of the dollar impact on just Iowa's rural hospitals?

Ms. **Williams**. Senator Grassley, we had those. I did not refresh my memory before I came.

Senator **Grassley**. Can you submit them for the record?

Ms. **Williams**. I sure can.

Senator **Grassley**. OK. What accounts for the high denial rate for cost outlayers under the PRO review?

Ms. **Williams**. I can't answer that question. That would be more aptly addressed to the PRO who makes those decisions.

Senator **Grassley**. Do you know if there are adjustments needed in those areas?

Ms. **Williams**. Well, we think that the cost outlayer should definitely be adjusted. Hospitals are looking—there are insurance companies now who are going to sell stop-loss insurance for DRG's, based totally on outliers. In a small hospital that large case is a magnificent, great portion of their care and their dollars, and it can impact so severely.

Senator **Grassley**. Do you have any data on the extent to which hospitals are moving into home health care services or other post-acute services where there seems to be a growing demand for the earlier discharge of patients?

Ms. **Williams**. Yes; we haven't actively collected and made a list of those, but I see newspaper articles, I see them in our Friday mailing, and many of the hospitals, as I intimated, now are working with that, networking within the community, now that the PPS provides incentives for them to diversify and expand and become a total health care network rather than just an acute care hospital.

Senator **Grassley**. Dr. Walter, from your vantage point do you feel hospitals are exerting undue influence on patient care decisions that were once made strictly by the physician?

Dr. **Walter**. I don't get that feeling, personally. And in talking with doctors throughout the State, I don't feel that that's a problem.

Senator **Grassley**. Is the relationship between hospital and physician changing as a consequence of the prospective payment system?

Dr. WALTER. I don't know that it's changing an awful lot now. I don't think it's physicians against hospitals. I think we still feel allied.

I think that if we get the DRG system for physicians, a lump payment, I think that then there'll be a lot of problems with that, physicians amongst physicians, and physicians and hospitals.

Senator GRASSLEY. Do you feel that physicians understand the responsibilities and procedures they face under the PPS medical review, and are you satisfied with the efforts of the Iowa peer review organization to educate physicians?

Dr. WALTER. Well, I think the Iowa Foundation and Iowa PRO does as good a job as they can do. I think that communication sometimes, when you deal with any organization, is not as good as it could possibly be. I think, too, that sometimes the communications that we get from the foundation give the impression that it's the foundation's decision, when really all it is is a passthrough. They're just passing on a regulation, a rule, or part of a law that has been passed, and they're just bringing the bad news to us. If that were made more clear, I think, to perhaps some physicians, they might not feel so much animosity toward the PRO and direct it more to where it belongs.

Senator GRASSLEY. Does that response also include the experience you've had, as chairman of a peer review organization, just at the district level?

Dr. WALTER. I think pretty much so. We work with physicians, and physicians do have some complaints about the way some of these single or individual rules are applied, or individual cases are handled. And we try to work through that in our peer review committee.

Senator GRASSLEY. We get letters from physicians on what is referred to as a "focus list" whose practices have a high proportion of elderly patients. To what extent do you feel this adversely affects the quality of care?

Dr. WALTER. I don't think it affects the quality of care, because I think, as has already been alluded to, I think physicians are still practicing as good a quality of medicine as they can. It adds to their stress. It bothers their decisionmaking and whether to really hospitalize a patient or not.

As far as I know, I'm not aware that a doctor has sent a patient home when he really felt he should be in the hospital. And my advice and our advice always has been that if you think someone should be in the hospital, then admit them to the hospital and take care of the other part of it later on.

Senator GRASSLEY. Do you find that patients understand the prospective payment system and medical review procedures?

Dr. WALTER. No; they don't.

Senator GRASSLEY. Do you find any increase in anxiety among Medicare patients based on misinformation or misunderstanding?

Dr. WALTER. Yes.

Senator GRASSLEY. Let me state that again, with the emphasis upon increased anxiety. In other words, within the last 2 years, as a result of this system, you've found a change in the level of anxiety compared to the previous period of less regulation?

Dr. WALTER. Well, yes. I think there's increased confusion, less understanding, and more anxiety.

Senator GRASSLEY. There's been some support by Congress for mandating second surgical opinion for elective surgeries under Medicare. Does your organization support or oppose such a proposal?

Dr. WALTER. Well, I think we do neither. We don't think there's enough information back on that to prove that it really saves in the long run, saves money.

Senator GRASSLEY. Do you feel that preadmission screening is sufficient to reduce unnecessary and inappropriate elective surgery?

Dr. WALTER. Well, I would think so. Preadmission screening is certainly as much as you should have to do. I think that some preadmission screening has been good. I think that probably we have outpatient surgical procedures now that we never did in the hospitals before, and I think they're working out well, and I don't think the quality of care to the patient has suffered.

Senator GRASSLEY. Do either of you have anything in closing? That's the last of my questions that I have for you.

Ms. WILLIAMS. I would make just one other remark, that I think is just a hallmark of what I've been saying: That if the Federal Government had set out to put rural hospitals out of business, they couldn't have done any better than the Medicare prospective payment system.

Senator GRASSLEY. Is it correctable, from your standpoint, and still maintaining the prospective payment system?

Ms. WILLIAMS. Yes; I think it is correctable.

Senator GRASSLEY. In other words, the inequity is what you're talking about——

Ms. WILLIAMS. Yes.

Senator GRASSLEY [continuing]. As opposed to the system?

Ms. WILLIAMS. Correct.

Senator GRASSLEY. Dr. Walter?

Dr. WALTER. Well, nothing. I just appreciate the opportunity to be here, and I do hope that we never get DRG's for physicians.

Senator GRASSLEY. Thank you very much.

Now I'd like to have the third panel, who are Karen Tynes, director of the State Office on the Aging, Bruce Butters, director of the Area One Agency on Aging, and Frank Crabb, vice chairman of the Iowa State American Association of Retired Persons, and he's vice chairman of the legislative committee.

I'd like to have you all come at once.

As I said in my opening statement, we're very interested in the effect that the prospective payment system is having on older people. So far, I think all of our witnesses have addressed this question one way or another. Now we will hear from individuals who approach this question from a different perspective, that of the individual older person and that of the advocates for the interests of older people.

In addition, this subcommittee—by the way, I don't think I explained, but this is the Subcommittee on Aging, which I chair, of the full Committee on Labor and Human Resources. That's the subcommittee that has come to Iowa for this hearing. In addition, this subcommittee, because it oversees the Older Americans Act and its programs, is interested in the implications for the Older Americans Act network of the prospective payment system. I have therefore asked all three of our witnesses on this panel to address this question as well.

Our first witness is Karen Tynes, and she's director of the Iowa State Office on Aging. Our second one is Bruce Butters. Bruce is director of the Area One Agency on Aging, and the chairman of the Iowa Association of Area Agencies on Aging; and our third one is Frank Crabb, as I indicated, and I knew Frank as a State legislator, a very successful business executive prior to his service in the State legislature. He's now retired from the State legislature and seems to be working as hard as he always did. So I want to say that I served several good years with Frank in the State legislature.

I would ask Karen to start, then Mr. Butters and Mr. Frank Crabb.

STATEMENT OF KAREN L. TYNES, EXECUTIVE DIRECTOR, IOWA COMMISSION ON THE AGING; BRUCE A. BUTTERS, EXECUTIVE DIRECTOR, AREA ONE AGENCY ON AGING, INC.; AND FRANK CRABB, VICE CHAIRMAN, IOWA STATE LEGISLATIVE COMMITTEE OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. TYNES. Thank you, Senator. We're very pleased that this hearing is being conducted in Iowa, and that you've asked the commission to also present some testimony on the prospective payment system. Unfortunately, we have few answers, but many questions and concerns regarding the effect the prospective payment system has had on elder Iowans and their loved ones.

The commission, of course, responds more to older people who are not in hospitals, but may be at risk of being hospitalized or institutionalized, or may be in transition.

The Iowa Commission on the Aging recognizes the need to reduce the cost of health care for our citizens of all ages. We recognize the seemingly uphill efforts of the Federal Government to curb these costs through the prospective payment system. It should be noted that while the Medicare prospective payment system may have addressed the Federal concerns, senior citizens are faced with increased out-of-pocket expenses and copayments under Medicare and still lack comprehensive protection against financial ruin from long-term catastrophic illness.

As the prospective payment system was implemented, many older Iowans were discharged from hospitals still needing intensive medical care. This has resulted in complications, readmissions, and in some instances, death. Much of the anecdotal information that has been relayed to the commission raises concerns about the future of the prospective payment system. Patients are being released much earlier from hospitals and are being sent to nursing homes which are ill prepared to address their heavy care needs. Even more at risk are those elders with heavy care needs who are released from hospitals to return to their homes in communities that lack programs of comprehensive community-based care.

Adding seniors and State unit on aging representatives to the boards of peer review organizations may help sensitize the PRO in some cases of admissions and discharges. However, adding consumer representatives and/or advocates will not change the Medicare/Medicaid regulations that affect access to care. For example, Medicare policy requires patients to be rehabilitable before they can receive temporary placement in a skilled nursing facility. Medicaid policy in Iowa follows this pattern. Individuals for whom the prognosis is maintenance are placed in an intermediate care facility. Too many ICF's are not equipped or reimbursed adequately to respond to the heavy care needs of this population and further deterioration in the status of these patients occurs. If consumers and/or advocates are on the PRO board, they may be able to facilitate some change in the manner in which the State chooses to implement Medicaid regulations.

Elders in rural States like Iowa are assured of less opportunity for sound choices for care upon being discharged from hospitals. Normal market mechanisms have developed home care agencies and nursing home beds in urban areas where there is a population base to support these alternatives. In rural areas in Iowa, there are limited comprehensive community-based long-term care programs and local nursing home beds have been filling quickly due to the implementation of the prospective payment system. When a patient could be discharged into the community, yet still requires rehabilitation services, the lack of transportation, especially in rural areas, is often the deciding factor against successful placement in their home. Until there are financial incentives for providers of service to expand services to rural areas there will be limited resources available in the community to support recently discharged patients with heavy care needs.

The PRO, of course, has no control over these demographic and economic realities. Again, consumers and advocates on the PRO board could be helpful as the link between enforcement of regulations and development of a sound support system for elders affected by the prospective payment system.

At the State level it is important to strengthen the relationship between the PRO and the State unit on aging. PRO's are data rich, and the aging network should utilize the PRO as an information resource. We believe the key to continuity of care for elders being discharged from the hospital rests in the coordinator.

Further development of community linkage is critical at this time. Pressure is being brought to bear in the linkages between hospitals, the community, and nursing homes by the prospective payment system. Where these linkages are not fully developed, quality of care may be jeopardized and there certainly will be a break in the continuity of care. Area agencies on aging must be more committed in their role as advocates and coordinators of services. They must strengthen the system to assure continuity of care and must become more involved as brokers of services between acute care and long-term care services.

The prospective payment system implemented under Medicare is now and will continue to have a profound impact on Older Americans Act programs. Funds appropriated under this act have tremendous flexibility in usage. More and more area agencies will be using these funds to pick up the loose ends to maintain continuity of care. Since it appears that substantial increases in funding will not occur, then a serious reallocation of existing resources must take place. To be effective in addressing those with the greatest need, resources will be diverted from popular, highly visible programs to serve the invisible, isolated elderly who have multiple needs.

Based on our data, we are confident that resources are being shifted from services to the well, mobile elderly to support services for elders with multiple problems. Area agencies will need to focus on assessment and case management activities balanced with outreach and information and referral services to effectively coordinate services to address the needs of seniors returning to the community as a result of the prospective payment system.

As a result of the graying of Iowa and the changing circumstances created for older Iowans by Federal regulations, we are entering a period of administration comprised largely of cut-back management and retrenchment. It is also a time for State units on aging to decide if funds will be devoted to less expensive services to many well, mobile elderly or to more expensive services to address the needs of the smaller population of the most at-risk elderly.

We are, even yet, just beginning to understand and measure the challenges we face. We welcome the Federal Government's involvement in preparing the Older Americans Act network for these changes.

Senator GRASSLEY. Thank you, Karen.

Mr. Butters.

Mr. BUTTERS. Mr. Chairman, I want to express my appreciation for the opportunity to testify here today. As you've said, my name is Bruce Butters. I'm the executive director of Area One Agency on Aging, serving five counties in northeast Iowa.

Area One Agency on Aging is the third smallest of 13 area agencies in Iowa in terms of its target population and budget. Approximately 7,000 persons aged 75 and older live in the area; 2,500 of them live alone in their own home; and 1,200 of them have an annual income below the poverty level.

I mention this for two reasons: First, my remarks today arise partly from observations, discussions, and experiences in my area, and it may benefit you to sense the thoroughly rural nature of that place.

I want to diverge here for a moment. I had written this with the mind to addressing those on your subcommittee that may not be from a rural area. I'm sure you're quite familiar with the rural nature of Area One.

Second, any discussion of the impact of the Medicare prospective payment system should consider the impact of this system upon those most seriously affected by its consequences: the very old, the alone, and the poor.

Our first concern as a society is and must be with the quality of care offered under PPS. Has it deteriorated? I suspect that the phrase "quicker and sicker" so commonly heard these days in regard to PPS hospital discharges was coined long before the first DRG was ever actually implemented but no one can deny that some, if not many, older persons believe that they or their loved ones have been discharged while still very ill. At any meeting of the elderly in my area I have only to raise the subject of DRG's to ensure a good 20 minutes of first- or second-hand accounts of premature hospital discharges. Each area agency director of my acquaintance has his own horror stories to share regarding these discharges.

What these tales actually mean in terms of percentages of premature release, I don't know. I have been struck by the lack of hard data available to me to assess the impact of PPS upon the quality of care. What information I get sometimes seems contradictory.

In my experience, hospitals do not always report to area agencies, and indeed, they have little incentive for even coordinating with us. Nor is the fault entirely theirs. Until recently, area agencies on aging saw their mission as a largely preventive one, helping to keep elderly persons active and independent. The institutionalized, the critically ill, these were the purview of those in the health care field.

Area agencies, as part of their mandate, routinely assess the needs of the population they serve to establish priorities. With each needs assessment comes the information that health care and its cost are the No. 1 concern for older people sampled. In my experience, area agencies have just as routinely, and justifiably, determined that they don't have nearly enough funds to even begin to directly address the health care needs of older persons. Health care, then, must be an advocacy issue for area agencies.

As an advocate, then, I'd like to reflect upon the impact upon quality of health care of PPS as it touches the lives of older Iowans.

First, most elderly, their children, and the public at large continue to be confused by the prospective payment system: how it works, and what their rights are within it. This, in itself, may explain many of the anecdotes that we hear from the elderly regarding PPS. For a time in Iowa, and perhaps still, hospital personnel themselves may have been confused as to the need to discharge patients under DRG's. The perception abounds that patients are being discharged because PPS requires it. At the very least, this confusion raises some anxiety on the part of elderly persons who may need to be hospitalized. Many elderly are postponing elective treatment for fear that a premature discharge from the hospital will leave them worse off than they were before.

In addition, we hear nearly as many stories of the hospital admission that was refused or seriously delayed because of PPS. Only 2 weeks ago I heard from an older man who accompanied his seriously ill brother to the hospital, where his admission was delayed for several hours while permission was sought from Des Moines to admit him. Ultimately, permission was granted. His brother was admitted to the hospital, where he later died. This man believes that the delay in care offered to his brother in this crisis contributed to his death.

At the very least, we can infer from his story that the process of peer review organization screening of this admission, or the way this process is administered at local hospitals, may result in unnecessary anxiety and discomfort in a time of crisis.

The attitudes of some physicians and other health care personnel may be changing regarding health care for the elderly. The prospective payment system itself runs the risk of encouraging a double standard of health care for the elderly. Questions regarding the ethics of performing very expensive medical procedures on the elderly have been raised. The practice of refusing renal dialysis for anyone over 50, for instance, has been cited as a reasonable cost-saving measure. Such suggestions only highlight the risk we run of allowing a two-tiered health care system to develop in our country.

As the director of an area agency in a rural area, I am quite interested in the impact of PPS upon rural health care. The inequity in the rate of payments made to rural hospitals as opposed to their urban counterparts has evidently worked a hardship on some hospitals, particularly those close to an urban hospital.

In response to PPS, hospitals are changing the way they look at their mission. A consultant to the Health Policy Corp. of Iowa issued a report last year in which he suggested several ways hospitals might expand their services to meet the financial crisis imposed upon them by PPS. Among the services he suggested hospitals might offer were chore, home health, transportation, and home-delivered meals, which are services already in place in most Iowa communities.

Hospitals are moving aggressively into the home health care field, and we in northeast Iowa are now experiencing what so many other communities in the country have—the emergence of the private, for-profit, home health agency. In our area, each county has a home health agency associated with its public health organization. In the last year, three for-profit home health agencies have started doing business in area one. A hospital located outside of our area also provides home health care within our area. You might think that 9 home health agencies in a small, rural area would be enough, but 5 of the 8 hospitals in our area have plans to enter the home health care field within the year, bringing the projected number of home health care agencies in the area to 14.

Where a hospital enters the home health field, it sometimes results in the absorption of an existing public health agency. Other times, the stance is frankly competitive. One local administrator, discussing plans for his hospital to take over the public health nursing agency, stated that whether or not the public health agency were merged with his hospital, the hospital would, nonetheless, offer home health services, that there was a different market for both agencies. Indeed, if the experience of the active hospital-based home health agency serving our area and a nearby area is any indicator, he is right. That agency refers its clients to the tax-supported public health agency as soon as the Medicare eligibility expires, presuming they haven't the private means to pay for services.

To date, some 12 public health agencies have been absorbed by hospitals in Iowa. Two major concerns arise from this trend. Hospitals enter the home health care market because they believe there is money to be made in it. There isn't, evidently, much money to be made in performing the other services we associate with public health, such as the WIC Program, well elderly clinics, communicable disease immunizations, and blood pressure screenings. Will a hospital assume the full public health responsibilities of the agency it absorbs? As I mentioned above, the second concern centers upon what will happen to the client when third-party payers disallow payment and the client cannot afford the service? Will the hospital continue to offer the service at a loss?

Public health agencies are also beginning to look at new ways to stay competitive in this new environment. For instance, some are planning to offer 24-hour, weekend, and holiday service. Others are implementing a greater level of care, such as intravenous maintenance. Yet Medicare regulations, as they apply to home health care, seem to tilt the playing field against the public health team, allowing up to 13 percent more for home visits by for-profit and hospital-based agencies than for public health agencies.

Home health care is not the only community and social health care service that has seen an increased demand because of PPS. A recent study of 160 area agencies on aging conducted by the Southwest Long-Term Care Gerontology Center shows that a majority of the agencies sampled reported an increase in 10 of 13 home care-related services as a result of PPS. The study showed a staggering 356-percent increase in case management, a 196-percent increase in in-home skilled nursing care services, a 69-percent increase in housekeeping services, and a 63-percent increase in personal care services.

There are strong implications for the Older Americans Act network raised by the advent of PPS.

First, there is a clear need for the development of a viable case management and assessment system to arrange for, oversee, and monitor the care given to persons affected by DRG's. Studies by the Rand Corp. suggest that decentralized home care in a competitive market can work only if there is a client advocacy system targeted at the truly at-risk elderly, assuring appropriate access to care at appropriate levels. Case management services by area agencies on aging have demonstrated their effectiveness in accomplishing this task. Two things are necessary, however, to see the development of a full case management system within the aging network. One, of course, is money. Area agencies which have implemented case management services have done so either at the expense of other top-priority services, or have seriously underfunded the case management project itself. Another necessary development is in the regulatory or legal authority of case managers. Hospital discharge planners should be required to work with case managers prior to the discharge of a patient. Case managers should have the authority to broker in-home services, to allow or disallow third-party payment to avoid overutilization.

As the resources of the network are more and more targeted exclusively to the frail, the ill, and the low-income elderly, the ability of area agencies to support their operations with project income will decline geometrically. Our agency, for instance, encourages older people of higher income levels to attend congregate meals. We do this because we have room for them, because they, too, benefit from congregate meals, and because they are able to contribute for their meal. Our average contribution in fiscal year 1985 amounted to nearly 50 percent of the actual cost of the meal. This high contribution rate has allowed our agency to expand the number of its meal sites from 12 in 1982 to 28 today. In each of those newly served communities, we have been able to offer home-delivered meals as well, an important service in an era of early hospital discharge. The day may come, however, as we move in response to PPS from a preventive mode of service into a maintenance mode, that we may no longer have room for those who aren't terribly needy. If it does, I suspect that the subsequent loss of project income will have serious consequences for our ability to support current levels of services.

The advent of DRG's has resulted in challenging and somewhat turbulent times in the community service and health care field. Those of us who work in the community need more than ever to cooperate and coordinate.

We need more practical research on long-term care systems. What is a viable system? How can one be implemented and funded?

How can we develop a system for tomorrow that will pursue the needs of the client as relentlessly as today's system pursues the elusive third-party payment?

On behalf of Area One Agency on Aging, I want to thank you again for giving us the opportunity to be heard here today, and I'd be happy to respond to your questions.

Senator GRASSLEY. Thank you.

Frank.

Mr. CRABB. Thank you, Senator.

As the Senator said, I'm a member of the American Association of Retired Persons and of the Iowa State Legislative Committee.

On behalf of the 216,468 members of the AARP in Iowa, which constitutes over one-half of all the people over 60 in Iowa, I want to thank you for bringing this important subcommittee to Iowa so that we can tell you and the Senate our views on the Medicare DRG prospective payment system.

The Medicare DRG system is 22 months old now, and all nonexempt hospitals participating in Medicare have begun the phase-in toward national DRG rates. Thus, it is a good time to step back, take a look at what is happening to patients under DRG's, and make necessary adjustments to the system.

My testimony today identifies three areas of concern about the implementation and operation of the DRG system so far.

I might stop here and say that there are now over 19 million members in AARP nationally, so the things that I'm saying here also have to do with the national situation. However, today we're going to talk about Iowa particularly.

First, the Health Care Financing Administration's failure to adequately monitor and correct for the economic incentives under DRG's to skimp on quality care.

Second, the serious lack of policy coordination and support of DRG's by contemporaneous HCFA policies; and

Third, the exacerbation of DRG's problems by ill-conceived, large reductions in the Federal health budget.

AARP concludes with several recommendations to improve the administration of DRG's.

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old cost-plus system, hospitals were paid for each service provided. The more services provided, the more money the hospital received. Thus, it was in the hospitals' interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRG's, however, those incentives are gone.

Under DRG's, hospitals have the opposite incentives—to perform fewer services and to get Medicare patients out of the hospital as soon as possible in order to maximize their profit. Moreover, new administrative rules and policies under DRG's limit Medicare patients' utilization of certain kinds of care and medical procedures.

The incentives inherent in the DRG system, combined with the new rules implementing it, substantially alter Medicare patients' rights under DRG's. This combination of structural incentives and administrative incentives jeopardize beneficiaries in two ways:

One, there is greater jeopardy to individual health status from skimping on services, and

Two, there is greater financial jeopardy for services now deemed to be noncovered and for services moved from the inpatient to the outpatient setting where greater cost-sharing is required.

The administration and the Congress must understand that these incentives are hurting Medicare patients. Although only anecdotal evidence is currently available to describe the effects of DRG's on patients, such evidence continues to mount.

HCFA policy decisions on other issues are having an adverse impact on Medicare patients under the DRG system. Apparently, HCFA does not appreciate the power of the incentives under DRG's to discharge patients quicker and sicker. HCFA is pursuing policies that foreclose increased access to postacute care services instead of fostering it. Access to skilled nursing home care and home health care are cases in point.

Access to skilled nursing home care has long been the forgotten promise of Medicare. For a variety of reasons, skilled nursing facilities have not been a reliable benefit for Medicare beneficiaries. In hopes of encouraging more SNF's to become involved in Medicare, Congress provided a mechanism for cushioning SNF's against wrong decisions about whether a patient is covered for SNF care. This cushion is called the waiver of liability. It is a presumption that an SNF acts in good faith if incorrect coverage decisions represent 5 percent or less of the providers' Medicare caseload. If an SNF meets the presumption, then Medicare will pay for the uncovered services.

In a recent notice of proposed rule, HCFA eliminated the waiver of liability by eliminating the presumption of good faith. The result of this change will be to further discourage SNF's from taking Medicare patients, thus making it even more difficult for postacute care patients to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers too. Home health care providers, however, face HCFA policies in addition to PPS that tend to foreclose access to home care. To qualify for home health services under Medicare, a patient must be homebound and in need of only intermittent care. HCFA has so restricted the definitions of homebound and intermittent care, however, that even the sicker patients coming out of hospitals under the DRG system are having trouble qualifying for postacute care services at home.

These conflicting, contemporaneous policy directions reduce the availability of postacute care services necessary to accommodate Medicare patients under DRG's. Hence, Medicare patients are being discharged from hospitals into a no-care zone.

The third area of concern affecting the prospective payment system is the ill-conceived Federal health budget proposals from the administration and the Senate. The association finds little to like in any of the proposals to cut the Federal health budget again this year. Most of the proposals simply shift costs to beneficiaries or providers; they contribute nothing to stabilizing Medicare or the health care system.

AARP has always believed that it is possible to contain health care costs and still provide high-quality health care. Incidentally, that's one of the little slogans that we send out many times during the year on posters and bulletins.

AARP recommendations for strengthening the DRG system are as follows:

AARP has always believed that it is possible to contain health care costs and still provide high-quality health care. We continue those beliefs. We are deeply concerned, however, that there has not been an adequate effort by HCFA to properly monitor and administer the system and coordinate contemporaneous policies that appreciate the problematic incentives created by the DRG system. This must change. AARP therefore offers the following recommendations:

One, if the Congress freezes DRG rates at 1985 levels, it should also freeze the transition to the national DRG rates.

Freezing the transition to the national DRG rates is necessary to help protect those hospitals that will be losers under the national rates. If the transition to national rates proceeds in spite of the freeze, then the loser hospitals will have even greater problems which, in turn, will affect patient care. Moreover, failure to halt the transition in light of the freeze would foster a two-tier health care system with Medicare beneficiaries relegated to the lower tier.

Two, the Medicare appeals procedures must be changed to reflect the greater beneficiary liability under DRG's. The changes should include formal hearing records and reported decisions under parts A and B as well as independent hearing examiners under part B.

Three, there must be a single national definition for homebound and for intermittent care. AARP favors either Senator Heinz' Home Care Protection Act, S. 778, or H.R. 2371, sponsored by Congressman Waxman.

Four, AARP has long supported a severity of illness index to help adjust hospital payments to reflect high-cost patients. In the absence of such an index, AARP is extremely cautious about arbitrary cuts in the allowance for indirect medical education costs. The indirect medical education costs act somewhat as a proxy for a number of factors, such as severity, which may legitimately increase costs in teaching hospitals.

Five, AARP believes that HCFA must reevaluate its approach to quality of care issues through the PRO's. PRO's must be allowed the flexibility and given incentive to be innovative, to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training, and consumer education ideas.

Six, the waiver of liability presumption for part A providers must not be revoked.

Seven, to validate the numerical reduction in identified medical procedures HCFA requires of the PRO's, AARP supports allocating 0.5 percent of HI revenues to study small-area practice variations and feed back the information to physicians.

AARP makes the following recommendations concerning the role of the aging network:

(a) Provide accurate information to older persons about the DRG system and their rights under it.

(b) Promote stronger linkages between community supportive services and hospital discharge planners; strengthen case management and advocacy functions.

(c) Direct more OAA resources to the frail and homebound.

(d) Strengthen research on long-term care and training for long-term care professionals.

(e) Through the long-term care ombudsman program, continue to monitor the DRG system, investigate and research complaints, and actively assess the DRG's impact on long-term care.

(f) Adequate funding must be provided for in-home services, home-delivered meals, research, training, and demonstrations.

Thank you again, Senator, for the opportunity to share the views of the American Association of Retired Persons on this critical area of policy.

[The prepared statement of Mr. Crabb follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON AGING

on

THE EFFECTS OF THE DRG PROSPECTIVE PAYMENT SYSTEM ON MEDICARE

August 5, 1985

Des Moines, Iowa

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EXECUTIVE SUMMARY
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1. If the Congress freezes DRG rates at 1985 levels, it should also freeze the transition to the national DRG rates.
   Freezing the transition to the national DRG rates is necessary to help protect those hospitals that will be "losers" under the national rates. If the transition to national rates proceeds in spite of the freeze then the "loser" hospitals will have even greater problems which, in turn, will affect patient care. Moreover, failure to halt the transition in light of the freeze would foster a two-tier health care system with Medicare beneficiaries relegated to the lower tier.
2. The Medicare appeals procedures must be changed to reflect the greater beneficiary liability under DRGs. The changes should include formal hearing records and reported decisions under Parts A and B as well as independent hearing examiners under Part B.
3. There must be a single national definition for "homebound" and

for "intermittent" care. AARP favors either Senator Heinz's Home Care Protection Act, S. 778, or H.R. 2371, sponsored by Congressman Waxman.

4. AARP has long supported a severity of illness index to help adjust hospital payments to reflect high cost patients. In the absence of such an index, AARP is extremely cautious about arbitrary cuts in the allowance for indirect medical education costs. The indirect medical education ocsts act somewhat as a proxy for a number of factors, such as severity, which may legitimately increase costs in teaching hospitals.
5. AARP believes that HCFA must reevaluate its approach to quality of care issues through the PROs. PROs must be allowed the flexibility and given incentive to be innovative -- to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training, and consumer education ideas.
6. The waiver of liability presumption for Part A providers must not be revoked.
7. To validate the numerical reduction in identified medical procedures HCFA requires of the PROs, AARP supports allocating 0.5 percent of HI revenues to study small area practice variations and feedback the information to physicians.

AARP makes the following recommendations concerning the role of the aging network:

A. Provide accurate information to older persons about the DRG system and their rights under it.

B. Promote stronger linkages between community supportive services and hospital discharge planners; strengthen case management and advocacy functions.

C. Direct more OAA resources to the frail and homebound.

D. Strengthen research on long-term care and training for long-term care professionals.

E. Through the long-term care ombudsman program, continue to monitor the DRG system, investigate and research complaints, and actively assess the DRG's impact on long-term care.

F. Adequate funding must be provided for in-home services, home-delivered meals, research, training, and demonstrations.

INTRODUCTION

Good morning, Mr. Chairman, my name is Frank Crabb and I am a member of the American Association of Retired Persons' Iowa State Legislative Committee. On behalf of the 216,468 members of the AARP in Iowa (constituting over one-half of all people over 60 in Iowa), I want to thank you for bringing this important Subcommittee to Iowa so that we can tell you and the Senate our views on the Medicare DRG prospective payment system. The Medicare DRG system is 22 months old now and all non-exempt hospitals participating in Medicare have begun the phase-in towards national DRG rates. Thus it is a good time to step back, take a look at what is happening to patients under DRGs, and make necessary adjustments to the system.

My testimony today identifies three areas of concern about the implementation and operation of the DRG system so far:

1. The Health Care Financing Administration's (HCFA) failure to adequately monitor and correct for the economic incentives under DRGs to skimp on quality care;
2. The serious lack of policy coordination and support of DRGs by contemporaneous HCFA policies; and,
3. The exacerbation of DRGs problems by ill-conceived, large reductions in the federal health budget.

Following the discussion of these points, AARP makes several recommendations to improve the administration of DRGs, including: changes in the Medicare appeals process, improved access and coverage for beneficiaries needing post-acute care services, and innovative efforts by peer review organizations (PROs) to monitor and enforce standards for quality care.

HOSPITAL INCENTIVES UNDER DRGs

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old cost plus system, hospitals were paid for each service provided. The more services provided, the more money the hospital received. Thus, it was in the hospitals interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRGs, however, those incentives are gone.

Under DRGs, hospitals have the opposite incentives -- to perform fewer services and to get Medicare patients out of the hospital as soon as possible in order to maximize their "profit". Moreover, new administrative rules and policies under DRGs limit Medicare patients' utilization of certain kinds of care and medical procedures.

For example, HCFA requires PROs to reduce identified procedures (the procedures vary from state to state) by specific amounts. PROs will be evaluated by HCFA based, in part, on how well they meet these numerical reductions. For most parts of the country, however, these numbers are based on little or no evidence that the procedures identified can be safely reduced without precluding access to necessary care.

Another example of a government requirement that places Medicare beneficiaries in jeopardy is HCFA's policy directive permitting hospitals to tell Medicare patients that certain services may not be covered by Medicare and that the patient is liable for payment if he or she goes forward with the treatment. This directive is a major new loophole in Medicare, and will result in greater out-of-pocket costs to beneficiaries.

The incentives inherent in the DRG system combined with the new rules implementing it, substantially alter Medicare patients' rights under DRGs. This combination of structural incentives and administrative incentives jeopardize beneficiaries in two ways:

1. There is greater jeopardy to individual health status from skimping on services, and
2. There is greater financial jeopardy for services now deemed to be non-covered and for services moved from the inpatient to the outpatient setting where greater cost-sharing is required.

The Administration and the Congress must understand that these incentives are hurting Medicare patients. Although only anecdotal evidence is currently available to describe the effect of DRGs on patients, such evidence continues to mount.

Evidence that DRGs are harming patients -

* In February, 1985, the House Select Committee on Aging held a joint hearing with the House Task Force on the Rural Elderly. The subject of the hearing was the quality of care under DRGs. Witnesses testified about problems of early discharge and lack of post-acute care services. One witness, a discharge planner for a large hospital in Minneapolis, told about the difficulties she had maintaining hospital care for her sick mother because the small rural hospital claimed her mother's allotted days of care under the DRG had run out. That hospital obviously did not understand the DRG system. There is no limitation on the number of days of care attached to DRGs. Beneficiaries still get up to 60 days of free care (after the Part A deductible) per spell of illness, if that level of acute care is necessary, despite the DRG.

Fortunately, the witness was knowledgeable about DRGs and was able to fight the hospital. Unfortunately, not all Medicare beneficiaries or their families are as familiar with the system and, therefore, are much more likely to acquiesce in the hospital's decision.

- On February 26, 1985, the Senate Special Committee on Aging released a report from the General Accounting Office on the impact of Medicare's new prospective payment system on post-hospital care. The report showed that Medicare patients are being discharged "quicker and sicker," too often with no place to go.

- On July 25, 1985, the Chairman of the Senate Special Committee on Aging, Senator John Heinz (R. PA), released information from the Department of Health and Human Services' Office of Inspector General documenting over 3,700 cases of premature discharge and inappropriate patient transfers under PPS as of March, 1985. There has been little corrective action taken on these cases.

- The American Association of Retired Persons is also trying to evaluate the scope and breadth of the problems affecting patient care under DRGs. The Association has received over 400 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers complaining about poor care and premature discharge under DRGs. The story that follows illustrates the anxiety and frustration encountered by Medicare beneficiaries and their families under the DRG prospective payment system.

- This example of the kind of mail the Association has been receiving on the DRG system was written by a 71 year old Medicare beneficiary in Texas. She is a retired R.N., with an artificial heart valve, writing about her own unhappy experience. She was admitted to the hospital because of a high temperature caused by an upper respiratory infection. Her artificial heart valve was an additional dimension of concern indicating hospitalization.

After being admitted she developed problems breathing and was placed on continuous oxygen and inhalation therapy three times a day. The night of her third day in the hospital inhalation therapy was required for the entire night. In addition, although she was expectorating "thick, purulent matter, tinged with blood," no one at the hospital was concerned enough to investigate.

On the morning of the fourth day in the hospital her doctor announced she was going home. When she protested, he said that the hospital had a new policy and that they now determined how long a Medicare patient could stay. She writes that her doctor was very upset - even "intimidated" by the hospital. He told her not to fight the hospital. She stated her fears about a relapse or dangerous complications, and refused to go home until her temperature was normal for 24 hours.

On the morning of the fifth day, the hospital's head nurse ordered her to go home and threatened, if she did not leave, to move her to a special floor with no heart or lung equipment and minimal nursing care; for such minimal care the patient herself was to be charged $65 per day. She was finally discharged the following morning.

After five weeks of recovering at home, she investigated the new Medicare DRG system and learned, among other things: that the hospital had a medical review board consisting of doctors, nurses, and other hospital personnel, but (1) that, in her case, it was a medical librarian who made the decisions about how long she could stay, and (2) that doctors feel pressured to discharge patients as the hospital dictates.

CONTEMPORANEOUS HCFA POLICIES AFFECTING DRGs

HCFA policy decisions on other issues are having an adverse impact on Medicare patients under the DRG system. Apparently, HCFA does not appreciate the power of the incentives under DRGs to discharge patients "quicker and sicker." HCFA is pursuing policies that foreclose increased access to post-acute care services instead of fostering it. Access to skilled nursing home care and home health care are cases in point.

Access to skilled nursing home care has long been the forgotten promise of Medicare. For a variety of reasons, skilled nursing facilities (SNF) have not been a reliable benefit for Medicare beneficiaries. In hopes of encouraging more SNFs to become involved in Medicare, Congress provided a mechanism for "cushioning" SNFs against wrong decisions about whether a patient is covered for SNF care. This "cushion" is called the waiver of liability. It is a presumption that a SNF acts in good faith if incorrect coverage decisions represent five percent or less of the providers' Medicare case load. If a SNF meets the presumption, then Medicare will pay for the uncovered services.

In a recent notice of proposed rule, HCFA eliminated the waiver of liability by eliminating the presumption of good faith. The result of this change will be to further discourage SNFs from taking Medicare patients, thus making it even more difficult for post-acute care patients to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers too. Home health care providers, however, face HCFA policies in addition to PPS that tend to foreclose access to home care. To qualify for home health services under Medicare, a patient must be "homebound" and in need of only "intermittent" care. HCFA has so restricted the definitions of "homebound" and "intermittent" care, however, that even the sicker patients coming out of hospitals under the DRG system are having trouble qualifying for post-acute care services at home.

These conflicting, contemporaneous policy directions reduce the availability of post-acute care services necessary to accommodate Medicare patients under DRGs. Hence, Medicare patients are being discharged from hospitals into a no-care zone.

The current post-acute care situation for Medicare patients can be compared to the deinstitutionalization of patients from mental hospitals in the 1970s. It was considered good public policy to close down mental hospitals in the early 70s and serve those patients in the community. Unfortunately, we never established a community based mental health care system to serve them. As a result, the lucky deinstitutionalized patients ended up in nursing homes under Medicaid; the unlucky ones ended up on the streets or in the criminal justice system.

The Association will not sit idle while Medicare patients are forced out of hospitals still needing care and without any place to go. If policymakers cannot provide the post-acute care services necessary under the incentives of the DRG prospective payment system, then it is time to change the system.

THE FEDERAL HEALTH BUDGET

The third area of concern affecting the prospective payment system is the ill-conceived federal health budget proposals from the Administration and the Senate. The Association finds little to like in any of the proposals to cut the federal health budget again this year. Most of the proposals simply shift costs to beneficiares or providers; they contribute nothing to stabilizing Medicare or the health care system.

The proposal to freeze DRG rates to hospitals at 1985 levels is particularly ill-advised considering we are in the middle of phasing-in a major change in how Medicare pays for hospital care. Freezing DRG rates is bad policy for several reasons: It is important that policy analysts understand the forces affecting behavior in the hospital sector under DRGs. To the extent that the freeze disrupts hospital behavior, it scrambles the data and makes it much more difficult to understand the cause and effect of moving to the DRG system. Moreover, the DRG system was sold on the promise that hospitals could keep the difference between the cost of delivering services and the DRG rate. Now the Administration wants to take back that difference. It is bad public policy for Congress to make promises inducing certain behavior and then to break those promises. The Congress should not be cavalier with its own reputation for veracity.

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F. Adequate funding must be provided for in-home services, home-delivered meals, research, training, and demonstrations.

Thank you again, Mr. Chairman, for this opportunity to share the views of the American Association of Retired Persons on this critical area of policy.

Senator **Grassley**. Thank you. I'll hasten right along with the questions. Hopefully, we'll be able to get through them all, but maybe I'll run out of time. If we don't, then if you'd cooperate, I'd like to submit in writing some of the questions. Let's see how far we can go.

There seems to be some disagreement not only among our witnesses here today, but also nationally, as to whether or not we do or do not have adequate information on what is happening in the prospective payment system to beneficiaries.

So, to each of you, do we know, in your opinion, about what is actually happening to the beneficiaries in Iowa, and if not, are your organizations making efforts to find out more about what is happening to them?

I'll start just across the line here.

Ms. **Tynes**. I believe that we are basing, as I said in my testimony, a lot of our information on anecdotal information that comes to the Commission, that we have limited facts and figures regarding quality of care under the prospective payment system. Again, our concern is not only in the hospital, but what happens after that patient is discharged earlier than usual and in need of some continuity of care. Nursing homes aren't prepared, the community is not prepared, families are certainly not prepared, to deal with those needs.

We are working with a number of organizations within Iowa to review—again, based on individuals' own testimony, not just the data that's available to the various professional organizations, but looking at the individuals' end and listening to their stories about what's happening, why are they falling through the cracks, why is it not working for them?

Senator **Grassley**. Mr. Butters.

Mr. **Butters**. I don't feel that I have adequate information to answer your question about what we're doing about it. We are going to do what we can to try to, as Karen indicated, find out more about what is happening to people after discharge. We don't have any statistics given to us from the hospitals regarding length of stay, anything of that nature, although I think those figures probably would be made available to us.

But, yes, we will be concentrating more upon trying to get a clearer, nonanecdotal picture of what is happening in our area.

Senator **Grassley**. Frank?

Mr. **Crabb**. We have quite a bit of information, but we don't think we have adequate information. We think there's a lot to be learned about the health care situation throughout the State and throughout the country.

And I would say this: That AARP is trying to find out more about it all the time. There isn't a week goes by that we who are on the legislative committee and the president of all the AARP chapters in Iowa, that they don't get letters—that we don't get letters, I should say—from our office in Washington asking us a lot of these same questions, and telling us what they think about it and what we should do about it—about finding out more about them, let people know about them, and then in the end, if we need help from our legislators, either State or Federal, to try to contact them—or to contact them, and tell them our views.

Senator **Grassley**. To Karen and Bruce, I want you to respond to the suggestion by Frank to the effect that area agencies on aging should be more involved in helping Medicare beneficiaries understand the prospective payment system. And actually, there's several questions here:

Are beneficiaries aware of their increased liability under DRG's?

Mr. **Butters**. I agree with them. It will be one of the efforts that we'll be undertaking in the next year. We have, just in preparation for this hearing, in visiting and meeting with older people it's quite clear just from the discussions that we've had that there's widespread misunderstanding about what the prospective payment system is. We have, in the past year, as the system has been implemented, run articles in our newsletter and held public meetings, as a matter of fact, with hospital administrators, to try to get the information across. Evidently it's going to be a long-term process.

Senator **Grassley**. Do you think area agencies should be doing this?

Mr. **Butters**. Yes.

Senator **Grassley**. And can they do it?

Mr. **Butters**. Yes.

Senator **Grassley**. And do they need any encouragement from the State or Federal Government in regard to this?

Mr. **Butters**. My belief is that as the need becomes apparent, then they will respond to it. I would remind you that in Iowa we've not been under the DRG system that long, when you look in terms of the planning cycles for area agencies to set their priorities. We're always working about a year in advance in terms of our planning. I think you'll see many more not only community service-type projects funded by area agencies that relate to the impact of DRG's, but the kind of informational efforts that will be required.

Senator **Grassley**. Do you think that—well, I should call it HCFA—do you think that HCFA and the peer review organizations should do more to be sure that hospitals are also well informed about what they must and must not do under PPS?

Ms. **Tynes**. A lot of our horror stories came when the system was beginning to be implemented in Iowa. We seem to be hearing less stories based upon hospitals' lack of knowledge of the system. So it would appear that HCFA and the hospitals have improved their communications as the program has developed in Iowa. I don't think that we can sit back and believe that there are enough communications. I think that any time an older person is at risk because of lack of information between HCFA and the hospitals, then we need to continue to prompt the two to talk.

Senator **Grassley**. Frank, you said in your statement that the peer review organization must be allowed to be flexible. I'm aware that your organization has been working on a project with the National Association of Peer Review Organizations, the intention of which has been to get consumers on those peer review boards.

What does your organization, AARP, hope to accomplish through this project, and what can you tell us about what has been accomplished along that line already?

Mr. **Crabb**. Here's one that I'm going to give you my opinion on, but I'm also going to get the policy out of Washington on it.

Frankly, we think more people should be on these boards that know something about it. In other words, boards that have to do with senior citizens, we think some senior citizens should be on there. We also think, however, they should be scrutinized; not just because somebody says, "I'd like to be on that board." What's their background? What's their thinking? And what do they think of their fellowmen? You can get some people who are very talkative, but I think you want to be very careful when you start selecting for a peer board that you get somebody who is openminded and who can think.

Senator GRASSLEY. For Bruce and Karen, both of you have stressed that area agencies must become more involved as case managers and as brokers between older people and appropriate services. You've also stressed the need to work more closely with hospital discharge planners. Is this something that the area agencies can do voluntarily on their own by developing better relations with hospitals, or do you think that some sort of State or Federal initiative should be used?

Ms. TYNES. Of course, the Commission on Aging would prefer to have the area agencies initiate this on their own. And on behalf of the area agencies in the State, that does exist at one level or another. I think area agencies really need to—not only in Iowa, but across the Nation—strengthen that role as the focal point for older people and the broker of service, the plan, or the coordinator in the community.

I think the area agencies in Iowa are working toward that. Area agencies in Iowa have not survived without that spirit of coordination and cooperation with other providers in the community.

Senator GRASSLEY. Bruce, did you have something to add to that?

Mr. BUTTERS. Yes. I'd add that it's also necessary, in coordination and cooperation, to have someone who's willing to coordinate and cooperate with you, and I think that at this point I'm not going to try to magnify the problem greater than it really is, but we've expressed our interest in our area in working with the hospitals to meet this crisis and to help plan in the communities, and we haven't, frankly, had a very good response from hospitals. In the changes that are being effected regarding hospitals and their community services, nobody has invited us to participate in the planning for this. And to be fair, we haven't specifically invited them to do this, and we should have. But I'm sensing that we will need some initiative on the part of the health care industry to accept our cooperative role.

Senator GRASSLEY. Karen and Bruce, again in response to Frank's suggesting in his statement that an ombudsman program could become involved in monitoring the workings of the prospective payment system and the postdischarge experience of beneficiaries, would you agree that this is something that we should start working toward, or what would be needed for this to become a reality?

Ms. TYNES. I believe we need to be very careful about changing the role of the ombudsman. If we're looking at the ombudsman still as being an advocate for the client or the individual in a long-term care facility, then I think that looking at perhaps other issues surrounding discharge under the prospective payment system would be in keeping with the current definition of the ombudsman program. However, if we're going to expand that person's role to be not just an advocate, but a technical person reviewing what physicians have already reviewed, doublechecking nurses and health care professionals in general, then we need to redefine the role of the ombudsman.

Senator GRASSLEY. Bruce?

Mr. BUTTERS. Specific to this State, I see some difficulties in the fact that our ombudsman position is currently administering and overseeing the care review committee—nursing home resident advocates—structure in Iowa, and that consists of—I don't know what the staffing level is now, whether it's one or greater than one—one person is responsible for recruiting and training probably 3,000 or 4,000 volunteers across the State to be nursing home client advocates. And I think that unless that were changed, it would be very difficult to add these additional duties to that position.

Senator GRASSLEY. I think I'll submit three questions to you in writing, if that would be OK, because I'm 5 minutes away from my next appointment down the road 2 miles. And so I'll have to say thank you for your participation, thank you to everybody who participated, plus those who have come to participate in the audience.

For those of you who would be moved, as I previously suggested, to submit your points of view on these issues, the record will remain open for 30 days, and you can submit those statements in writing to my office in Washington or to the Subcommittee on Aging of the Senate Committee on Labor and Human Resources. I'm the chairman of that subcommittee. You can submit those for inclusion in the record, and I'll see that that's done.

[Additional material supplied for the record follows:]

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October 17, 1985

Senator Charles E. Grassley, Chairman
Subcommittee on Aging
Committee on Labor and Human Resources
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Grassley:

Thank you for your letter of October 9, and the additional questions.

This letter will respond to those questions.

Do you think that the Health Care Financing Administration and the Peer Review Organization should do more to be sure that hospitals are also well informed about what they must do or must not do under PPS?

I don't know what HCFA and the PRO have done to date to inform hospitals of what to do and what not to do under PPS. If the reports I hear from older people in my area of difficulties with premature discharges and delayed admissions are true, then there is room for improvement, since they would reflect a misunderstanding of PPS requirements.

The National Association of Area Agencies on Aging made a major proposal in 1983 to greatly increase the involvement of the area agencies on aging in the long term care area. Do you know when N4A will be releasing what I understand will be a modified version of that proposal?

I am informed by Nancy Gorshe of the N4A staff that this proposal will be part of the N4A Legislative Statement to be released in January of 1986.

Nationally, in Fiscal Year 1985, somewhere in the neighborhood of $135 million was raised through participant contributions. This is a very large amount of money in the context of the Older Americans Act budget. Mr. Butters has also pointed out that older people who attend meal sites in Iowa contribute very generously and that this money is plowed back into the program.

As this program presently works, is it possible to use the voluntary contributions made by the Title III participants for some of these services that we are talking about here today? That is, for Case Management and the like? Who controls how those contributions are used and what they are used for? Does there have to be any change, in your opinion, in the way this is handled by the present law and regulations?

I believe that most of the participant contributions generated by the Older Americans' Act come from Title III-C Nutrition Projects. These contributions by law must be used to "increase the number of meals served..., to facilitate access to such meals, and to provide other supportive services directly related to nutrition services." These restrictions effectively prevent contributions from being applied to other, non-nutrition needs.

In my opinion, several legislative and regulatory steps need to be taken to free up these dollars for application in the areas of long term care and other pressing priority needs.

First, there must be clarification within the Older Americans' Act and its corresponding rules, that participant contributions will revert and belong to the Area Agency on Aging, not to the subcontracting service provider. Only in this way will the Agency be able to depend upon these funds in planning for other priority needs. As the rules now stand, there is considerable ambiguity as to who controls these funds, with Nutrition subcontractors many times insisting that they do. This ambiguity can result in difficulties for an Area Agency who must deal with such a subcontractor-- that Area Agency has no good control over the handling of contributions by the subcontractor, yet the Area Agency is still legally responsible for their disposition.

Next, there must be changes to the Act which would permit Nutrition contributions to be used for other services as determined necessary by the Area Agency and its Advisory Council. As the law now stands, an Area Agency could indirectly use such funds by requesting a transfer of funds from Title III-C to Title III-B to support long term care services, and by making up the difference in the Nutrition Program with III-C contributions. This method, however, clearly has potential difficulties, not the least of which is that the III-C contributions do not result in an increase in the number of meals, but only a maintenance of the normal level of service.

And finally, there should be regulatory changes, specifically, to CFR 45, Part 74 and related OMB Circulars regarding the acceptable options for use of project income. Area Agencies could best develop and plan for support of long term care services with project income if they could depend upon using project income from the prior year, knowing the exact figure and that it would still be available to that area. Many aspects of current Federal regulations prohibit or severely restrict the ability of a grantee to "carry over" project income from year to year, insisting instead that any positive fund balance at the end of the Fiscal Year be considered unspent Federal funds to revert back to the Federal government or, alternatively, to be used for allowable purposes within the same Fiscal Year in which it was generated.

I think it would be very risky to embark upon the delivery of vital long term care services without knowing whether adequate funding were available to maintain such services for an entire fiscal year. To depend upon as yet unearned Project Income to support such services would be dangerous, since many external factors can affect the level of Project Income.

Changing Federal regulations to simplify the budgeting of unspent project income into the next Fiscal Year would not only allow better planning, but would probably eliminate end-of-year "binge" spending that seems to occur in some states. And it might encourage other Federal grantees outside of the Older Americans Act network to as aggressively pursue local funding as we have.

Mr. Crabb, you stated in your remarks that we need more reserach on long term care systems and more training of people who work in the long term crae area. Some of the Long Term Care Gerontology Centers funded under Title IV of the Older Americans Act, the money the Commissioner on Aging uses at her discretion, may not be refunded this year, or so it has been rumored.

Should we insist that these centers continue to be refunded? What do you think about this?

I believe, as does Mr. Crabb, that there is a need for research on long term care and other aspects of aging. It is, however, somewhat difficult to answer your question in the affirmative. As the Director of a small, rural Area Agency on Aging, I must wonder as to the specific product of such research. Either no substantive products have come out of such research endeavors, or there is inadequate communication between the Long Term Care Gerontology Centers, because I'm unable as local long term care provider to identify any such products in our daily work.

I believe that research is vital to improving the quality of our lives, but I also believe there must be a open and two-way dialogue between the research institutions and the actual service providers who might benefit from such research.

Senator Grassley, I want to thank you again for the opportunity to testify before your subcommittee.

Sincerely,

Bruce A. Butters
Executive Director

QUESTIONS FOR KAREN TYNES: FROM SENATOR CHARLES GRASSLEY

1. An important question is how we might pay for some of the alternative services you have argued are increasingly necessary as a consequence of the prospective payment system.

One source of such funds could be the discretionary provision available under Title III of the Older Americans Act. As you know, last year when we reauthorized the Older Americans Act, we raised the percentage of Title III funds which could be shifted within the Title III programs to 30 percent.

To what extent has this provision be used in Iowa, and how exactly has Older Americans Act money been moved among programs?

Do you know why more money has not been reallocated into the types of services we are talking about - case management, in-home services, and the like - given especially that the need would seem to be great in the areas we have been talking about?

2. Nationally, in fiscal year 1985, somewhere in the neighborhood of $135 million was raised through participant contributions. This is a very large amount of money in the context of the Older Americans Act budget. Mr. Butters has also pointed out that older people who attend meal sites in Iowa contribute very generously and that this money is plowed back into the program.

As the program presently works, is it possible to use the voluntary contributions made by the Title III participants for some of these services that we are talking about here today? That is, for case management and the like?

Who controls how those contributions are used and what they are used for? Does there have to be any change, in your opinion, in the way this is handled by the present law and regulations?

3. Mr. Crabb stated in his remarks that we need more research on long term care systems and more training of people who work in the long term care area. Some of the long term care gerontology centers funded under Title IV of the Older Americans Act, the money the Commissioner on Aging uses at her discretion, may not be refunded this year, or so it has been rumored.

Should we insist that these centers continue to be funded? Karen and Bruce, what do you think about this?

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Terry E. Branstad
Governor
Karen L. Tynes
Executive Director

October 29, 1985

The Honorable Charles Grassley
Room 317
Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Grassley:

I appreciated the opportunity to testify on the Medicare Prospective Payment System during the hearings you conducted in Des Moines. I am pleased to respond to the questions you raised in your letter of October 9, 1985 and hope that you will not hesitate to contact the Iowa Commission on the Aging for information in the future.

Following are my responses to your questions:

I. While the Older Americans Act now provides states with authority to transfer up to 30% of Title III B and Title III C funds, Iowa has transferred a negligible amount. The area agencies on aging in Iowa have not expressed a great desire to shift funds, yet the need for more costly, personal services has increased along with the number of old, old individuals in Iowa. Trying to address the growing needs of this population by reallocating existing resources merely creates a deficit of services for another segment of the elder population and/or causes increased pressure for participants to contribute more cash to the Title III C program.

Transferring funds from nutrition services to social/supportive services is politically a difficult move for area agencies. The congregate meal program is the most visible program operated under the Older Americans Act. The most articulate elders participate in this program which is a favorite among elected officials. Decreasing the size of this program to increase services to elders who are often invisible because they are homebound is not easily understandable by those who most enjoy it.

II. Participate contributions for services received under Title III B and Title III C may be transferred from one Title to the other. Of the expended $3,762,625.00 contributed under Title III C in FY '85, we document a transfer to Title III B of $28,186.00. The decision to transfer these funds is that of the area agencies on aging.

In Iowa the area agencies indicate their intent to expend projected project income in their area plan which must be approved by the Commission. In my opinion, the present law and regulations governing project income are adequate.

III. Some regional Long-Term Care Gerontology Centers have been very helpful in the development of a coordinated system for delivering long-term care to elders. Unfortunately, training provided by the regional centers is often limited to a few states within the region and may not be of benefit to other states in the nation. Research conducted by the centers has not been fully utilized by Older Americans Act programs. I believe these centers should continue to be funded on a competitive basis.

I hope you find my comments helpful.

Sincerely,

Karen

Karen L. Tynes
Executive Director

KLT/kaj

The Osteoporosis Foundation

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EXECUTIVE DIRECTOR

John B Wright

July 30, 1985

Senator Charles Grassley
Subcommittee on Aging
428 Dirksen
Washington, D.C. 20510

Dear Senator Grassley:

Enclosed are my answers to your questions and to those of Senator Metzenbaum. We are most appreciative of the interest you and your other subcommittee members have expressed in osteoporosis and in our Foundation.

1. Is it advisable that a younger person who wishes to commence a personal program or routine to prevent osteoporosis consult at the outset a physician who is knowledgeable about this condition?

We would always advise individuals who have health-related questions to contact a physician. For healthy, younger people, our current level of knowledge indicates that obtaining an adequate calcium intake, regularly engaging in weight bearing exercise, and avoiding excessive use of calcium-wasting substances such as caffeine and alcohol might well be the best preventive measures. A responsibly informed public would not need to discuss these issues with a physician. One of the major tasks of our Foundation will be to so inform the public, thus obviating the possible unnecessary use of the formal health care system.

2. -You mention that primary care physicians, who might be in the best position to intervene medically, are inadequately informed about osteoporosis. What would you suggest we do to remedy this? What is your Foundation planning to do about this problem?

The assumption that physicians are inadequately informed about osteoporosis is accurate. Much needs to be done. First, informing the public is a very important strategy, since physicians are increasingly responsive to public pressures for information and care. Second, the education of physicians in training should receive priority. To accomplish this, the Foundation plans to provide educational materials to those key individuals at teaching hospitals who are responsible for clinical training of medical students and house physicians in relevant specialties and in primary care. We will also offer the services of a speakers' bureau for the same purpose. Third, the education of physicians in practice will be pursued by providing educational materials to their community hospitals and encouraging those hospitals to use the speakers' bureau. Fourth, we are examining the possibility of providing educational materials to physicians directly, to establish a physician's newsletter, and to establish a physician's "hot line" about osteoporosis. The development of regional Osteoporosis Foundation affiliates which have lay and professional membership should facilitate this undertaking. Fifth, we will use the media for educational purposes whenever possible.

The Osteoporosis Foundation is a nation-wide non-profit educational and research foundation.

3. Can you tell us from where you will draw your funds for the Foundation?

As a non-private Foundation, we are ultimately required to draw much of our funding from the public, in the form of small gifts. I believe that the IRS, recognizing difficulties in starting a Foundation, gives us several years to achieve that goal. Consequently, we anticipate that our start-up funds will derive from corporations and private foundations, as well as substantial gifts from private individuals. Our case statement and written requests for corporate giving are now being finalized and we should be approaching the corporations within the next month.

4. What is your target for funding? How much money will you try to raise?

We would like to raise two million dollars by the end of 1986 and we have set a five-year goal of twenty million dollars. As indicated above, we anticipate that, early on, these funds will be derived largely from corporate and private foundation giving. We are beginning to plan a major public event for fund raising as well.

QUESTIONS FROM SENATOR METZENBAUM

1. How are you funded at the present time?

Pharmaceutical houses have provided "start-up funds" for our organizational efforts.

2. Is the plan to staff the Foundation primarily with volunteers?

Of course the Board of Trustees and the Board of Scientific Advisors will be volunteers. At the outset, we plan to have a paid professional executive director and secretary. As the Foundation begins to approach its mission, added paid professional staff, in-house/or extramural, will be required. We also plan to use volunteers for many of our activities, an undertaking which would be facilitated by developing regional chapters or components of the Foundation. One model we have utilized in planning is that of the Arthritis Foundation.

Again, please accept my thanks for your interest and specific questions. Also, we would welcome any suggestions that you might have about any phase of our activity.

Sincerely,

William A. Peck

William A. Peck, M.D.
President

WAP/rd
0975R

cc: Executive Committee Members

ST. JOSEPH MERCY HOSPITAL

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SINCE 1892

July 20, 1984

Mr. Richard P. Teske
Associate Administrator for External Affairs
Office of Intergovernmental Affairs
Department of Health and Human Services
Health Care Financing Administration
200 Independence Avenue S W
Washington, D. C. 20201

Dear Mr. Teske,

I would like to thank you for your visit to Cedar Rapids Tuesday and the opportunity to discuss the Prospective Payment system. Your candor and openness was most appreciated. I recognize the enormity of the development of a hospital reimbursement system that provides incentives for cost containment, while continuing to guarantee access and improve the health status of the population.

As a result of your visit, I would like to take this opportunity to comment on three areas that were the center of Tuesday's discussion. These are the concern of the management staff and the Divisional Board of St. Joseph Mercy Hospital on controlling health care costs, and our efforts in this regard; the situation faced by Clinton and the impact of the urban-rural distinction; and finally, some suggestions for revising the system.

St. Joseph Mercy Hospital shares the Federal Government concern over escalating health care costs. Over the past three years we have placed major emphasis on productivity and cost containment. We have significantly eliminated positions associated with inpatient care and instituted a wage freeze for the 1984 calendar year. Our total audited expense for the fiscal year 1982 was $12,107,000. A fiscal year budget for 1985 anticipates a total expense of $13,099,000. This represents an overall increase of 8.2% total operating budget since 1982. At the same time, we have successfully reduced inpatient utilization by promoting outpatient services when possible and engaging, in concert with the Medical Staff, in an effective Utilization Review program. Today, approximately half of all surgery is done on an outpatient basis. The results of Utilization Review have been dramatic. In fiscal year 1982 the average length of stay for all patients was 7.2 days. This fell to 5.7 days in June, 1984, and resulted in an overall 6.2 average length of stay during the fiscal year. Next year we are anticipating an average length of stay of 5.5 days. The combination of these factors have drastically reduced inpatient census, despite our successful efforts to increase market share.

The effect of decreased inpatient census has been a challenge to management which we have successfully met. However, the prospect of significantly reduced reimbursement from Medicare because of the Urban-Rural distinction will seriously effect the hospital and threaten health care delivery in Clinton. Although being classified as rural, Clinton has similar characteristics in terms of health care costs to the Davenport/Rock Island metropolitan statistical area. Clinton is located approximately thirty miles north of Davenport and ten miles from the Scott County line. The total Federal portion of Davenport's hospital's base rate is $3,007.21. In Clinton, the corresponding figure is $1,984.11. St. Joseph Mercy Hospital's T.E.F.R.A. target rate was $2,573.38. This difference, over time, will erode our ability to maintain present services, let alone provide for replacement capital and new technology.

The largest portion of these disportionate rates is accounted for by the labor component. When wage and indices are applied, the difference is $799.15 between Clinton and Davenport. Our hospital has, and must continue to, compete with hospitals in the Davenport area for employees. The size of this differential is not reality and certainly not equitable. I have enclosed for your review the compilation of average wages for various occupations comparing Scott County (Davenport), Dubuque County and Clinton County. It also includes the wage rates paid by St. Joseph Mercy Hospital. These wage rates were taken from the Job Service of Iowa figures. I feel they demonstrate Clinton County is very comparable to these two counties, and not "rural" in terms of wage rate. Certainly a 33% difference is not evident. The labor component for St. Joseph Mercy Hospital is much more similar to the Davenport/Rock Island metropolitan statistical area than rural hospitals in South Dakota, Nebraska and Iowa.

The non-labor component is similarly disproportionate. There is not a $223.95, or 54%, difference between Clinton and "urban" hospitals in Region Six. Supplies are the largest part of the non-labor component. St. Joseph Mercy Hospital belongs to the Mercy Coordinating Council. The Council negotiates contracts with the vendors for all hospitals in the Council, who then buy on a common price structure. Over seventy-five percent of the hospitals belonging to the Council are in urban areas. Thus, our hospital is paying the same price for supplies as our fellow institutions in urban areas. Other elements of the non-labor component, such as utilities and food, are similar in Clinton to those prices paid in Davenport. The only item that I can conceive that would be disportionately expensive in a major metropolitan area would be the medical malpractice insurance, because of the incidence of litigation.

I would like to emphasize the concept of prospective payment is valid and an excellent step toward your overall objective of capitation. However, I feel it is imperative to address the inequities in the interim Prospective Payment System in order to protect the viability of health care services in Clinton, and communities such as Clinton, throughout the country.

Therefore, my suggestion for the Health Care Financing Administration would be to consider:

1. Significantly reduce base rates for all institutions covered by the Prospective Payment System.

2. Eliminate urban and rural distinctions for the labor component. Utilize one national rate, adjusted for a health wage index, instead of overall data from the Bureau of Labor Statistics.
3. Eliminate the urban and rural distinctions for the non-labor component entirely.
4. Expand the differences and the weights assigned to the various Diagnostic Related Groups. This would emphasize the intensity of service to a much greater extent.
5. Slightly expand the number of Diagnostic Related Groups to recognize the multi systemic disorders that are associated with poverty and the lack of primary health care services.

Again, I would like to thank you for your interest and receptivity in addressing the problems associated with the Prospective Payment System. I would appreciate the opportunity to discuss this matter with you in further detail. You would be most welcome to visit St. Joseph Mercy Hospital and personally view an "urban" rural hospital.

Sincerely yours,

Samuel L. French
Senior Vice-President

SLF/sjh

cc: Tom Tauke

CLINTON-DAVENPORT COMPARISON

Region 6

	Wage Component	Non-wage Component
Urban	2401.03	636.44
Rural	1922.71	412.49

Clinton (rural) wage index .8174

1922.71 (.8174) + 412.49
1571.62 + 412.49
1984.11

Davenport (urban) wage index .9874

2401.03 (9874) + 636.44
2370.77 + 636.44
3007.21

	Wage Component	Non-wage Component	Total
Davenport	2370.77	636.44	3007.21
Clinton	1571.62	412.49	1984.11
	799.15	223.95	1023.10

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WAGE COMPARISON

Compiled from Job Service
of Iowa Wage Surveys
1983 Data

Weighted Averages - All Industry Comparison

PART A: Relevant Hospital Occupations

	Clinton County	Scott County	Dubuque County	SJMH
Accountant	13.51	10.33	10.44	10.73
Buyer	10.84	11.23	9.55	15.17
Quality Control Tech	9.74	12.53	6.76	7.36
Acct. Clerk	5.75	6.71	6.24	8.26
Billing Clerk	6.73	7.31	7.57	6.04
Secretary	6.98	7.13	5.70	6.09
Stock Clerk	8.76	8.43	5.64	5.02
Janitor	7.72	6.08	6.23	5.25
Watchguard	9.79	5.32	6.34	6.68
Maintenance Mechanic	11.05	11.75	7.65	9.62
Licensed Practical Nurse	6.07	6.13	7.26	7.21
Employment Manager	12.47	11.18	11.64	9.00
Pharmacist	11.80	11.52	12.60	12.05
Registered Nurse	9.46	7.28	9.88	9.20
Social Worker	8.03	8.23	8.40	7.26
X-Ray Tech	7.45	8.56	7.50	8.03
Housekeeper	5.21	4.55	4.43	5.13
Cook	4.35	4.97	4.97	5.78

PART B: Other Benchmark Positions

	Clinton County	Scott County	Dubuque County
Computor Programmer	7.50	9.68	9.01
Dental Assistant	5.42	4.94	4.92
Loan Officer	12.41	10.78	10.65
Office Manager	8.10	11.06	8.92
Retail Store Manager	7.23	9.91	7.77
Production Supervisor	9.48	16.21	11.28
Construction Superintendent	14.59	15.89	13.38
Bookkeeper	5.52	6.45	6.62
General Office Clerk	5.31	5.92	5.90
Key Punch/Tape Operator	3.94	6.62	6.29
Statistical Clerk	6.34	7.87	6.30
Sales Representative	8.53	12.13	10.06
Salesperson	3.97	5.02	4.83
Restaurant Chef	4.51	5.24	5.28
Short Order Cook	3.51	4.32	3.69
General Laborer	5.54	7.27	6.16
General Inspector	7.94	12.08	7.85
General Machinist	12.42	11.01	7.42
Production Assembler	6.29	10.45	6.20
Carpenter	10.68	12.84	10.83
Eletrician	13.36	16.09	7.69
Heavy Equipment Operator	11.83	13.11	10.77
Maintenance Electrician	11.21	12.50	8.68
Plumber	14.60	16.02	7.88
Welder - Arc	11.47	15.14	9.13
Industrial Truck Operator	7.36	10.97	7.69
Material Handler	6.80	9.63	6.68

Senator GRASSLEY. I want to say that this record, particularly as it relates to Iowa, will be a source of information on an interim review that is related to some of my initiatives in regard to changing the PPS formula, a small part of some major problems with it, but also it's part of a record that will be accumulated along with others now ongoing as to what we have all committed ourselves to, a third-year review of this program, when it was originally set up in October 1983.

So thank you all, and I hope to be hearing from you.

This meeting is adjourned.

[Whereupon, at 3:40 p.m., the hearing was adjourned, subject to the call of the Chair.]

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